DEPARTMENT OF SOCIAL & HEALTH SERVICES
CHILDREN'S ADMINISTRATION

BEHAVIORAL REHABILITATIVE SERVICES HANDBOOK

JULY 1, 2006

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➢ 1. BRS GENERAL GUIDELINES

1.1. What are Behavior Rehabilitation Services?

The Behavior Rehabilitation Services (BRS) program is an intensive support and treatment program for children with behavioral/emotional disturbances, developmental disabilities, and medically fragile, designed to assist in increasing stability, functioning, increase the potential to achieve permanence and transition to a less restrictive environment. The goal of these services is to stabilize the child's level of functioning, help him/her acquire skills, and develop necessary supports which would allow the child to maintain or develop a permanent family connection and to reside in his/her own community with less-intensive service level.

A wide array of services can be provided under a BRS contract, ranging from Short-Term/Emergent Care to On-going Services. Short-Term/Emergent Care services may include Assessment Services – limited to 90 days – and Interim Care Services – limited to 180 days. On-going services are limited to 18 months. Services can be delivered in the child's home, a treatment foster home, or facility.

1.2. How are Behavior Rehabilitation Services (BRS) referrals made?

"Home region" refers to the DSHS region in which the Contractor's headquarters is located. The CA BRS Regional Manager in the Contractor's home region is the gatekeeper for placement of DSHS-paid children. The Contractor must receive approval from the Contractor's home region BRS Regional Manager before accepting referrals served under the BRS contract.

1.3 What actions shall be taken if there are additional concerns or presenting problems that were not stated in the CA referral?

If the Contractor determines that there are additional health and safety concerns, suspected substance abuse and/or other presenting problems, which were not stated in the CA referral to the Contractor, the Contractor shall immediately report this information to the CA Social Worker. The verbal notification shall be followed by written notification within 72 hours.

1.4 Are there any additional policies that must be followed when serving youth through the Division of Developmental Disabilities (DDD) Voluntary Placement Program?

The Contractor shall also follow DDD policies 5.14, 5.15, 5.16 15.01, 15.02, 15.03, 15.04, 15.05 and 5.14 *(see appendix)* when serving DDD enrolled youth through the DDD Voluntary Placement Program. In addition to the aforementioned DDD policies, the Contractor shall adhere to Infant Toddler Early Intervention Program (ITEIP) policies when serving children age birth to 3 years old.

1.5 What "change-in-status" notifications are required?

- The Contractor shall inform the CA/DDD referring Social Worker and the regional BRS manager immediately when a youth's status changes for any of the reasons listed below. The Contractor shall follow-up verbal notification with written notification by fax or E-mail to the DSHS social worker and the regional BRS manager within 24 hours.

- The Contractor shall also inform the youth's parents within 24 hours when a youth's status changes for the reasons listed below unless the information would endanger the youth; or unless specific circumstances and procedures for parental contact are identified in the youth's Individual Service and Safety Plan (ISSP) or by the assigned CA Social Worker.

- The Contractor shall follow all reporting requirements regarding missing children as defined by WAC 388-148-0010 and WAC 388-148-0123 which state:

  "Missing child" means:
  (1) Any child up to eighteen years of age for whom Children's Administration(CA)has custody and control(not including children in dependency guardianship) and:
  (a) The child's whereabouts are unknown; and/or
  (b) The child has left care without the permission of the child's caregiver or CA.
  (2) Children who are missing are categorized under one of the following definitions:
  (a) **"Taken from placement"** means that a child's whereabouts are unknown, and it is believed that the child is being or has been concealed, detained or removed by another person from a court-ordered placement and the removal, concealment or detainment is in violation of the court order;
  (b) **"Absence not authorized, whereabouts unknown"** means the child is not believed to have been taken from placement, did not have permission to leave the placement, and there has been no contact with the child and the whereabouts of the child is unknown; or
  (c) **"Absence not authorized, whereabouts known"** means that a child has left his or her placement without permission and the social worker has some contact with the child or may periodically have information as to the whereabouts of the child.

  What are my reporting requirements when children are missing form care?
  (1) As soon as you have reason to know a child in your care is missing as defined in WAC 388-148-0010, or has refused to return to or remain in your care, or whose whereabouts are otherwise unknown, you or your staff are required to notify the following:
  (a) The child's assigned social worker, if the child is in the department's custody;
  (b) CA intake, if the social worker is not available or it is after normal business hours; or

(c) The case manager if the child is placed by a child-placing agency program.

(2) You or your staff are required to contact local law enforcement if the child is missing as defined in WAC 388-148-0010 within six hours. However, if one or more of the following factors are present, you must contact law enforcement immediately:

(a) The child has been, or is believed to have been, taken from placement as defined in WAC 388-148-0010;

(b) The child has been, or is believed to have been, lured from placement or to have left placement under circumstances that indicate the child may be at risk of physical or sexual assault or exploitation;

(c) The child is age thirteen or younger;

(d) The child has one or more physical or mental health conditions that if not treated daily will place the child at severe risks;

(e) The child is pregnant or parenting and the infant/child is believed to be with him or her;

(f) The child has severe emotional problems (e.g., suicidal ideations) that if not treated will place the child at severe risk;

(g) The child has a developmental disability that impairs the child's ability to care for him/herself;

(h) The child has a serious alcohol and/or substance abuse problem; or

(i) The child is at risk due to circumstances unique to that child. After contacting local law enforcement, the Washington State Patrol's (WSP) Missing Children Clearinghouse must also be contacted and informed that the child is missing from care. The telephone number for the Clearinghouse is 1 (800) 543-5678.

(3) If the child leaves school or has an unauthorized absence from school, the caregiver should consult with the social worker to assess the situation and determine when law enforcement should be called. If any of the factors listed in subsections (2)(a) through (h) of this section are present, the caregiver and the social worker may decide it is appropriate to delay notification to law enforcement for up to four hours after the end of the school day to give the child the opportunity to return on their own.

(4) The caregiver will provide the following information to law enforcement and to the social worker when making a missing child report, if available:

(a) When the child left;

(b) Where the child left from;

(d) Any known behaviors or interactions that may have precipitated the child's departure;

(e) Any possible places the child may go to;

(f) Any special physical or mental health conditions or medications that affect the child's safety;

(g) Any known companions who may be aware of and involved in the child's absence;

(h) Other professionals, relatives, significant adults or peers who may know where the child would go; and

(i) A recent photo of the child.

(5) The caregiver should obtain the number of the missing person report and provide that number to CA staff.

- **REASONS FOR NOTIFICATION:**

  - Significant change in mental health status, supervision or safety needs of the youth
  - Juvenile justice system involvement with youth
  - Changes in medical condition, e.g., emergency room treatment, hospitalization, diagnosis of disease or condition
  - Any allegations of abuse or neglect reportable by statute shall be reported to both CA Intake and the CA/DDD Social Worker
  - Youth changes foster homes, returns home, etc.
  - Any unusual incident that seriously impacts the youth's health, safety, or well being.

1.6 What is considered to be an "incident"?

An "incident" is a disruption in normal routine of the home as a result of a conflict between youth, youth and Contractor's staff, or as a result of an external disturbance.

1.7 What actions must be taken when an incident occurs?

- The Contractor shall notify the CA/DDD assigned Social Worker within 24 hours when an incident occurs involving a youth in the Contractor's care.

- The Contractor shall follow-up with written notification to the CA/DDD referring Social Worker within 24 hours. The incident report shall include:

  - Circumstances leading up to the incident
  - A description of the incident with the date, time and location
  - Response by Contractor's staff
  - Response by the youth(s) involved in the incident
  - Sanctions imposed or recommended for the incident

- The Contractor shall also notify DLR in accordance with DLR requirements.

1.8 What actions should be taken if the youth or his or her family misses a scheduled appointment?

The Contractor shall:

- Document missed appointment in the client file.

- When specific appointments are specified in the ISTP and the youth or family misses the appointment, the contractor shall:

- Immediately notify the CA/DDD Social Worker by phone of the missed appointment; and

- Fax written notification to the CA/DDD Social Worker within one working day of missed appointment

1.9 What happens if the contractor wants to stop serving a child and family?

The contractor must make every effort to serve children within that the contractor's system. If a contractor wants to stop serving a child and family under their BRS contract, the contractor must provide 30 days written notice to DSHS, unless there is a written agreement between DSHS and the contractor that an immediate change must occur.

1.10 What steps must be taken when transitioning a youth from care?

The contractor shall convene a Child and Family Team Meeting to include the youth's social worker before transitioning a youth from the Contractor's program to their family or other placement or to independent living.

The Contractor shall review the youth's safety plan with individuals who have a role in monitoring the child's safety before the transition takes place. The Contractor shall complete a CFARS and Youth Transition Report, along with a discharge summary.

1.11 Are Contractors required to attend Child Protective Team (CPT) meetings, prognostic staffings or other formal staffings?

The Contractor shall participate in Child Protective Team (CPT) meetings, prognostic staffings, fatality reviews, or any other formalized staffings when requested by DSHS to attend specific meetings or staffings. In the event that the Contractor is unable to attend a meeting or staffing, the Contractor shall provide a written report of information needed for the meetings or staffing.

1.12 Can client records be released to the Office of the Family and Children's Ombudsman?

The Contractor shall release records relating to services provided to a youth that are dependent under Chapter 13.34 RCW, to the Office of the Family and Children's Ombudsman (OFCO). The Contractor can release the records without the consent of the dependent youth's parent or guardian or the youth if the youth is under the age of 13 years, unless law otherwise specifically prohibits such release. The Contractor shall notify the BRS Regional Manager when the OFCO makes a request for records.

1.13 What services must be provided for Limited English Proficient clients?

- In accordance with DSHS policy, the Contractor shall provide Limited English Proficient (LEP) clients with certified or qualified interpreters and translated

documents and shall provide deaf, deaf-blind, or hard of hearing clients with the services of a certified sign language interpreter. Interpreter and translation services shall be provided at no cost to the client. All interpreter and translation costs shall be the financial responsibility of the Contractor. These costs are included in the rate.

- Extraordinary costs, which create an undue hardship for the Contractor in providing interpretation and/or translation services to an individual client, may be reviewed and addressed for supplemental reimbursement by the Regional Administrator on a case by case basis.

- BRS is a service package that potentially includes room and board, informal services that happen in the course of daily living, and formal services as identified in the youth's service plan. All of these elements should support the youth's personal growth and development and contribute toward the remediation of the client's presenting problems. As such, youth with LEP must have a mechanism for communication in their native language during all waking hours, including meals and free time. This requirement may be met in a variety of ways: through the use of contracted interpreters; through the use of bi-lingual staff or volunteers who have been certified or qualified through a DSHS language fluency examination; or by the use of the ATT Language Line. Contractors must choose a mechanism appropriate to the situation.

1.14 How shall culturally, ethnically and religiously relevant services be provided under BRS?

- The Contractor shall provide accessible services to clients that are culturally relevant and respond to each client's cultural beliefs and values, ethnic norms, language needs, religion, and individual differences. Service providers are encouraged to employ a diverse workforce that reflects the diversity of their clientele and the community.

- In order to ensure that services are culturally relevant, the Contractor may need to obtain consultation from a consultant who is recognized by the community at, or prior to, the initial planning meeting.

1.15 What factors must be considered in delivering services to children?

- Services shall be provided in accordance with BRS Provider Qualifications *(see appendix).*

- The services must be individualized and respond to the identified needs of the client. Recommendations from DSHS generated evaluations or screenings shall be considered in the service plan.

- Family focused services shall be provided and the contractor shall encourage active involvement of the family team.

- The contractor shall ensure supervision of staff providing direct services.

- Services shall be accessible and culturally appropriate.

1.16 Will payment be paid when a youth is on the run, in detention or hospitalized?

A. CA shall pay for temporary absences of children from BRS only in compliance with WAC 388-25-0180. In addition, the following conditions shall apply:
    1. CA shall not pay for absences of a child from BRS, unless there is an agreement with the Contractor for the child to return to their placement within 15 days.
    2. When a child leaves a BRS placement, unless there is agreement by CA and the Contractor to place the child back into their placement, the social worker shall for pay only for the actual days of care provided, not including the last day of placement. Acceptable absences, where the plan is to return the child to the foster home within 15 days, include:
        a. Planned visitation;
        b. Hospitalizations;
        c. Attendance at summer camps and similar activities;
        d. Respite placements;
        e. Temporary placement while Treatment foster parent(s) is vacationing or receiving medical treatment;
        f. Juvenile detention placement of youth; or
        g. Runaways when the bed is being held for the return of the child.
    3. An exception to policy (ETP) may be submitted to the Regional Administrator to continue payment beyond 15 days of absence or when a planned absence is for a reason other than listed above, if continued payment is necessary to continue a plan of care which is in the child's best interests. Payment for absences with Regional Administrator of designee approval shall not exceed 30 days.

1.17 Can I limit or censor the mail or phone calls of children and youth I am serving?

Children and youth served by your program generally have a right to private phone calls and uncensored mail. Contractors shall discuss with the social worker and/or determine from the ISSP whether there are individuals with whom contact is not allowed or there are any other circumstances that require monitoring of mail or phone calls. Unless such circumstances dictate, children and youth shall be allowed uncensored mail and phone calls, in accordance with your house rules.

1.18 What assessments are required?

- ***Children's Functional Assessment Rating Scale (CFARS)***
  The Contractor shall complete a CFARS on each youth at a minimum, but not limited to within 14 days of entry and within 30 days prior to exiting BRS. If youth is being served under interim care the Contractor shall complete a CFARS upon entry, but only complete a CFARS upon exit if youth is served for a period longer than 60 days.

The Contractor shall, at a minimum, but not limited to, complete a CFARS on youth currently in BRS longer than 30 days, at the time of the youth's quarterly report, then within 30 days prior to exiting BRS. If the youth is discharging on or before the next quarterly report a CFARS is not required.

The Contractor is not required to complete a CFARS on youth being served under the Medically Fragile or Developmentally Disabled (3A, 3B, 3C) service levels.

➢ 2. BRS PROGRAM SERVICES FOR YOUTH

2.1 Who convenes the Child/Family Team Meeting?

- The Contractor shall have the responsibility of convening and developing the framework for an individualized child/family team. The Contractor is responsible for facilitating the child/family team meetings unless otherwise instructed by the CA Social Worker. This team will form the basis for a network of community support for the client. The youth shall have a role in identifying people who should be on the child and family team. The CA Social Worker shall be a member of the team. Other child/family team members should include:

  - Immediate family members
  - Extended family members
  - Foster parents
  - Concerned professionals
  - Concerned community members
  - Other natural supports
  - Other significant individuals identified by youth
  - Tribal members when appropriate.

- In the event a child/family team has already been developed, the contractor shall work cooperatively with the existing team. The contractor, CA Social Worker, and child/family team shall evaluate team membership and appropriate adjustments shall be made.

- Child and Family Team meetings shall be convened in collaboration with the CA Social Worker, no later than 30 days after entering services and 30 days prior to the child exiting services. These meetings should be designed to engage the child and family in order to maximize their respective involvement in the case plan. If the child is in Assessment or Interim care services there may only be time to convene one Child and Family Team meeting.

2.2 What is the role of the Child and Family Team?

An individualized child and family team composed of natural and system supports is a key component in developing the support network necessary for a youth to make a successful transition from resource intensive care to less intensive services. The Contractor shall ensure that the team is involved in the development of the ISTP and IBMP and involved with all major decisions pertaining to the client.

2.3 What steps shall be completed upon a youth's admission?

- **HEALTH ASSESSMENT**: Ensure the youth is assessed to identify any emergent or chronic health needs that require immediate attention. The Health Assessment shall be completed within 24 hours of intake. The Health Assessment shall include, but not be limited to the following:

  - Identification chronic medical issues
  - Identification immediate health concerns
  - Identification follow-up action needed
  - Identification if a emergency or medical appointment visit is necessary immediately
  - Identification if the EPSDT needs to occur
  - Signature of the BRS staff completing the form, along with the time and date completed

- **PROGRAM ORIENTATION:** Provide an orientation within 8 hours of the youths admission to the program for the youth, which shall include but not be limited to:

  - Behavioral expectations
  - Method for contacting the CA/DDD Social Worker
  - Crisis Response Protocol for the youth and caregiver

- **INDIVIDUAL BEHAVIOR MANAGEMENT PLAN (IBMP):** The Contractor shall develop a proactive IBMP with input from DSHS and from the youth within 24 hours of their start date in your BRS program. The IBMP must identify strategies and consequences to be used in managing behavior specific to youth's presenting problems. This plan shall take into account factors of all children residing in the same placement to ensure their safety and protection. Family members and/or Foster Parents shall be involved in the development of the plans and shall have copies of the plans. The IBMP plan shall be reviewed and updated 30 days after initial intake, then at least every 90 days as the needs, issues and/or behaviors of the child change. The IBMP may be part of the ISTP or separate document. The IBMP must be available for all BRS staff. In addition to specific behavioral goals, the IBMP shall include the following components:

  - ***Individualized Supervision Plan*** which addresses:

    - ✓ Supervision needs
    - ✓ Other youth with whom the youth will interact
    - ✓ Interactions with the community

  - ***Individualized Safety Plan*** which addresses:

    - ✓ Safety issues for the youth
    - ✓ Factors that may contribute to escalated behavior for the youth
    - ✓ Preferred response strategies for preventing or defusing escalated behavior
    - ✓ Back-up plan for de-escalating behavior

- ✓ Behavior management goals aimed at reduction of unsafe behaviors through skill building
- ✓ Crisis response plan

- The Contractor shall obtain signatures from the youth's CA/DDD Social Worker, parent, and the youth if 13 years old or older. If the youth is placed in a foster home, the foster parent must also sign the IBMP.

  If the CA/DDD social worker, parent or foster parent signature is unattainable, the Contractor shall document why the parent did not sign the IBMP.

➢ **INDIVIDUAL SERVICES AND TREATMENT PLAN (ISTP):** The Contractor shall develop an ISTP within 30 days of the youth's start date in the BRS program. The CA/DDD Social Worker, the Contractor's social service staff, the youth and the youth's family and/or the foster parents shall participate in the development of the ISTP. The ISTP must address all of the major needs and risk factors identified by DSHS and identify members of the child/family team. The contractor shall be responsible to ensure the needs stated in the ISTP are met. The ISTP must be readily available for all BRS staff. The ISTP shall be reviewed and updated every 90 days. The ISTP shall include the following components:

- ***Assessment:*** An assessment of the youth and family's current level of functioning, strengths, treatment needs and support needs.

- ***Permanency Plan:*** A permanency plan for the child and an indication of how the current intervention strategies support the goals of the permanent plan. In addition to the primary plan, an alternate plan for permanency shall be included.

- ***Discharge Plan:*** The discharge plan and estimated time frame for discharge.

- ***Goals:*** Goals that describe short-term benchmarks of success for the child and family. These benchmarks shall be used in determining when a child and family are ready for less intensive supports.

- ***Intervention Strategies:*** A description of how identified strengths will be utilized to meet identified treatment and support needs.

- ***Strength Utilization:*** A description of how identified strengths will help the child and family achieve the individualized goals.

- ***Assignment of Responsibility:*** A method for assigning lead responsibility and time frames for the completion of treatment and support system development tasks.

- ***Child/Family Team:*** A method for identifying child/family team members and their role in providing support to the child/family team.

- ***Independent Living Service Plan (ILS)*** for all youth who are age 16 or over. Please see Section 1.9 regarding ILS plans and services.

- ***ISTP Signatures:*** The Contractor shall obtain signatures on the ISTP from the following parties: the youth's DSHS social worker, parent, contractor's social service staff, the youth, if 13 years old or older, and the foster parents if the youth is in a foster home placement. If the parent's signature is unattainable, the Contractor shall document why the parent did not sign the ISTP.

2.4 What are the guidelines for Independent Living Skills (ILS)?

1. The Contractor shall assist youth age 15 years and older in out-of-home care with enrichment opportunities regarding independent living skills that they will need upon turning age 18. Such essential skills will help ensure the youth's ability to live independently. ILS for youth 15-17 should be provided by a contracted ILS provider.

2. The Contractor shall provide enrichment opportunities for youth ages 13 through 14 that primarily focuses on successful school achievement and the skills critical for negotiating early adolescence.

3. In coordination with the assigned CA Social Worker and where services are available, all ILS eligible youth shall be referred for services to a contracted ILS provider. The Contractor is not responsible for payment of ILS services by a contracted ILS provider. If no contracted ILS provider is available, the Contractor shall assist the youth in completing the following ILS assessment and plan:

   a. Complete an assessment of the youth's current ILS skills using the Ansel Casey Life Skills Assessment. The ACLSA can be accessed at http://www.caseylifeskills.org/ .

   b. Ensure that the youth has a written ILS plan that defines services to be provided which will assist the youth to become self-sufficient in the following areas:

      - Education *(GED, or high school completion, post-secondary education etc.)*
      - Income maintenance *(budgeting, opening and maintaining a checking/savings accounts, comparative shopping, etc.)*
      - Housing *("know-how" to securing adequate housing, i.e., rentals, shared housing, transitional living housing resources, etc.)*
      - Vocational goals *(obtaining marketable skills, job search skills, work place expectations, volunteer or employment experiences, etc.)*
      - Daily living skills *(cooking, chores, transportation, community resource access, etc.)*
      - Interpersonal skills *(communication, anger management, dating, parenting, etc.)*

   c. Assist with the completion or update of the ILS plan as follows:

      (1) Determine if a plan has been developed for the youth. If the youth has a current plan, the Contractor shall review, assist with the update and revise the

plan in collaboration with the youth and ensure the plan addresses the elements described above under item b of this section.

(2) If the youth does not have a plan, assist in developing a written plan in collaboration with the youth using the Ansel Casey Life Skills Assessment. The plan shall address the elements described above under item b of this section. The ACLSA can be accessed at http://www.caseylifeskills.org/ .

d. Submit the following reports to the youth's assigned CA/DDD Social Worker within 15 days of completion:

(1) Assessment of the youth's current ILS skills
(2) ILS Plan

4. The Contractor shall assist with the update of the ILS plan every 90 days and shall incorporate the plan into the ISTP.

5. The Contractor shall assist the youth in identifying, establishing and maintaining connections with significant adults. This can be accomplished by working with appropriate adults the youth already has a connection with or by assisting the youth to obtain a mentor.

6. If the youth is expected to exit the BRS program to independence, the Contractor shall work with the youth's child/family team to ensure the youth has:

- ✓ Adequate housing
- ✓ A means of financial support
- ✓ Connections to adult supports
- ✓ Connections to needed services

2.5 What services shall be provided for each youth?

- **BEHAVIORAL SERVICES**: Behavioral assessment and intervention as indicated in the IBMP, either as part of the contractor's service network or in conjunction with community resources. Options for intervention should include individual, family and group services.

- **COUNSELING AND THERAPY:** The contractor shall advise or give guidance to the family and child(ren) and provide services or activities intended to remedy or alleviates a disorder or undesirable condition. BRS youth are also eligible to be screened through the Regional Support Network (RSN) for Mental Health Services. The BRS contractor shall be responsible for activities specific to the child's behavior in the youths setting. These services shall focus on behavior rehabilitation directly related to the child's level of functioning. The provider shall be responsible to ensure the needs are met that are stated in the ISTP. Activities focused on long term family

reconciliation goals or resolution of issues underlying the behavioral problems, may be provided by the RSN or other private practitioners.

- **SUBSTANCE ABUSE SERVICES:** Substance abuse assessment, education, treatment and relapse prevention shall be provided where indicated either as part of the contractor's service network or in conjunction with community resources.

- **CASE MANAGEMENT SERVICES:** Oversight of the IBMP/ISTP; communication and coordination with community partners, family, foster family, DSHS staff, and other child/family team members.

- **EDUCATIONAL SERVICES:** Educational services shall be provided either by means of an on-ground self-contained education program or through the use of public schools. DSHS is not responsible for education costs, including a 1:1 school aid for a youth. When, or if the contractor needs support with the public school, the Contractor shall utilize educational advocate resources to ensure the youth is receiving all appropriate services. CA has the authority and may, but not obligated to provide BRS for youth from eighteen through twenty years of age to enable them to complete their high school or vocational school program (RCW 74.13.031). The continuation of services for 18-20 year olds shall only occur if the following criteria are met;

  - Youth continues to attend high school or equivalent program and agrees to stay in care complying with all CA and Contractor placement requirements.
  - CA agrees to continue to pay for BRS.
  - The Contractor agrees to continue to provide BRS.

  BRS for 18-20 year olds may be terminated if the above criteria are not meet or for any reason deemed appropriate by CA or the Contractor.

- **HEALTH CARE SERVICES:** To include emergency care, routine health care, health maintenance and disease prevention services such as: nutrition, hygiene, pregnancy prevention, preventing sexually transmitted infections, etc. The Contractor must comply with the provisions of RCW 13.34.060 *Authorization of Routine Medical and Dental Care and* Chapter 71.34 RCW *Mental Health Services for Minors*, for children prescribed psychotropic medication. Per Chapter 71.34 RCW and CA policy 4541, consent for the administration of psychotropic medication can only be given by;

  - The parent of the child or
  - CA social worker if child is legally free or with a court order authorizing administration or
  - The child is age 13 or older and competent to give consent on their own behalf.

  If the child gives consent on their own behalf the Contractor must clearly document the consent and place the documentation in the child's records. The contractor shall also submit a copy of this documentation to the CA social worker.

- **REMEDIATION AND STABILIZATION:** Education and other services focused on skill acquisition, stabilization of behaviors and resolution of conflicts shall be offered. Options for intervention should include individual, family or group services and shall be provided either as part of the contractor's service network or the contractor shall arrange for these services in the community. The cost of these services shall be the financial responsibility of the Contractor. These costs are included in the rate.

- **COMMUNITY SUPPORT DEVELOPMENT:** Efforts shall be made to identify and develop linkages to support the family and child to facilitate the child's continued success in the community where the child will reside.

- **TRANSPORTATION:** Routine transportation for youth in care shall be the primary responsibility of the Contractor. Routine transportation shall include, but not be limited to transportation to: educational, recreational, medical and counseling and/or other therapeutic services, visitation and community support development appointments. The Contractor shall also assist with transportation upon transition into and out of their program, based upon the agreement with the CA Social Worker. The Contractor shall ensure the supervision and safety of the youth while providing transportation as outlined in RCW 46.61.687 Child passenger restraint requirements and WAC 388-148-0210 What requirements do I need to follow when I transport children.

  At the discretion of DSHS, DSHS may pay for non-routine travel. The Contractor must obtain prior written approval for all non-routine travel from the CA Regional Administrator, or designee.

2.6 Are youth served under BRS required to have an EPSDT?

Youth served under BRS are eligible for health care screenings through Early Periodic Screening Diagnosis and Treatment (EPSDT) administered in Washington State as the "Healthy Kids" program. The Contractor shall arrange for an EPSDT screening for each youth within thirty (30) days of placement. If a youth has a current EPSDT exam upon placement, the Contractor shall facilitate the process for the youth to obtain an inter-periodic screening. The Contractor shall facilitate annual EPSDT health screenings thereafter. A licensed professional healthcare provider shall perform the screening. The Contractor shall follow through with obtaining or providing any recommended treatment or services. If the youth is being served outside the State of Washington, the provider will identify a similar service for the youth.

The Contractor shall submit the EPSDT results to the CA Social Worker within 15 days of receiving the EPSDT results from the healthcare provider.

➢ 3. BRS PROGRAM ADMINISTRATION

3.1 Who is responsible for assuring youth health and safety?

- In the delivery of services under this Contract, youths' health and safety shall always be the first concern of the Contractor.

- The Contractor shall be responsible to assure the health and safety of all clients served.

- The Contractor shall provide services which help alleviate immediate danger to the child and if working with the family provide services which aid parents alleviate potential future endangerment of their child.

3.2 Is mandated reporter training required?

The Contractor shall ensure employees view the "Making a CPS Referral: A Guide for Mandated Reporters" video provided by DSHS within two (2) weeks of initial employment. After viewing the video, each employee shall sign and date a statement acknowledging his or her duty to report child maltreatment and the Contractor shall retain the signed statement in the employee's personnel file.

3.3 What actions must be taken if child abuse is suspected?

- Contractors are mandated reporters under Chapter 26.44.030 RCW. The Contractor must immediately report all instances of suspected child abuse to (1) CA Intake and (2) the assigned CA Social Worker. All verbal notifications shall be followed by written notification within 72 hours.

- CA Intake shall make the determination of whether the referral constitutes an allegation of Child Abuse or Neglect that shall be accepted for investigation, a possible Health and Safety Deficiency, a licensing issue or a matter of "information only".

3.4 What is the requirement for case consultation?

The Contractor shall secure case consultation to address individual clients' needs from individuals recognized by the community as experts in the following service areas. Consultation shall be provided at a rate of no less than ½ hour per client per month averaged over a three-month period. Consultants may be hired as staff or operate under a contract with your program.

Areas of expertise as appropriate to types of youth served:
- Behavior and emotional disabilities
- Sexually aggressive behavior
- Developmental disabilities
- Medically fragile children
- Other areas which address client needs

The Contractor shall ensure that during and following any consultation, the consulting professional shall understand and observe confidentiality rules associated with patient information that are required by law and by their professions. All consultation shall be documented in the client's file.

The qualifications and expectations for professional consultant as stated in WAC 388-148-0600 are:

- A master's degree from a recognized school of social work or similar academic training in the field they will be advising
- The training, experience, knowledge and demonstrated skills in each area that he or she will be supervising
- The ability to ensure your staff develop their skills and the understanding needed to effectively manage their cases.

3.5 What are the job qualifications for a social service staff?

- At a minimum there shall be, one person who provides social services must have a master's degree in social work or a closely allied field from an accredited school:

- Social service staff without a master's degree in social work or closely related field must have a bachelor's degree in social work or closely related field. A person with a master's degree must consult at least eight hours per month with any social service staff who has only a bachelor's degree.

3.6 What is the maximum caseload size per social service staff?

- The contractor must limit caseloads to 25 cases per social service staff.

3.7 What are the job responsibilities of a case manager and/or social service staff?

Case Managers and/or Social service staff shall have the primary responsibility of planning, developing and implementing services for youth. Social service staff shall collaborate with DSHS in delivering services to each youth:

- Arranging for counseling as described in the ISTP.

- Coordinating mental health, drug/alcohol, medical or other treatment as described in the ISTP.

- Reviewing and participating in the development of the youth's Individual Education Plan (IEP) in coordination with the child/family team. Advocating with the local school district to ensure that the youth receives appropriate educational services.

- Coordinating and ensuring inclusion of the child/family team in planning and decision making processes.

- Providing on-going assessment of service and support needs of the client. Advocating for youth to be moved to a less intensive support structure as functioning improves.

- Ensuring that services provided are documented in the individual client file.

3.8 What are the job qualifications for a case manager?

- Masters Degree in Counseling or Social Work or closely allied field

OR

- Bachelors Degree in Counseling or Social Work or closely allied field, with two year experience working with children and families.

3.9 What is the maximum caseload size per case manager?

- The contractor must limit caseloads to an average of 10 BRS cases per 1 FTE case manager, with a maximum of 12 cases. Factors to be considered in determining whether caseload size should be smaller include but are not limited to:

  - size/density of geographic location
  - scope of case manager's job responsibilities
  - differences in the population being served
  - number of sibling groups.

- Should a contracting agency wish to have specific caseloads larger than 12, it must submit a plan of how the case manager will successfully manage the increased caseload.

3.10 Is BRS staff required to attend training?

All BRS staff that have unsupervised contact with clients providing supervision, recreation, or any other activity or individuals who supervise these staff shall attend 30 hours of training annually and it shall be documented in the staff's social service summary. The contractor must also provide 30 hours of training annually to all BRS professional staff. Topics offered must be based on the staff members' needs for skill development, their interests, and the issues of the children they are serving. The training shall also be relevant to the staff's specific job duties. . If a Case manager has a youth assigned to their case load with a history of sexual assault/aggression or physical aggression they shall have specific training focused on the safety and supervision or these youth.

3.11 Who must receive a criminal history background check before delivering BRS?

- This Section applies to employees, volunteers and subcontractors only. This section does not apply to licensed foster parents who are affiliated with the Contractor.

Licensed foster parents are subject to the criminal history background provisions associated with obtaining and maintaining a current foster license.

- The Contractor shall initiate a criminal history background check through the Children's Administration pursuant to RCW 43.43.832 and 43.43.834, for all prospective employees, volunteers and subcontractors who may have unsupervised access to DSHS clients. Such persons shall not have unsupervised access to youth in care until a satisfactory background check is completed and documentation qualifying the individual for unsupervised access is returned to the Contractor.

- Background checks completed through Division of Licensed Resources (DLR) shall be acceptable under this requirement.

- In addition to a satisfactory background clearance through the Children's Administration, the Contractor shall obtain a fingerprint background check through the FBI for all prospective employees, volunteers, subcontractors and other persons who may have unsupervised access to DSHS clients if such persons have resided for less than three (3) years in the State of Washington. If the Contractor elects, pursuant to RCW 43.43.832 (7), to provisionally hire a person who has resided in this state for less than three years pending the results of the required FBI background check, the Contractor shall not permit that person to have unsupervised access to children who are served under this contract or under any other contract with the Children's Administration until a satisfactory FBI background check is completed. If the FBI check disqualifies the applicant, RCW 43.43.832 requires DSHS to notify the Contractor that the provisional approval to hire is withdrawn and that the applicant may be terminated.

3.12 What measures must be taken to assure client confidentiality?

- The Contractor shall not disclose information on individuals directly or indirectly except in compliance with state RCW, WAC and federal law.

- The Contractor shall not use or disclose any information concerning any DSHS client for any purpose not directly connected with the administration of the Contractor's responsibilities under the Contract unless the Contractor obtains prior written consent from the client and provides prior notification to CA.

- If the client is a dependent child and is not of legal age to provide consent, the Contractor must obtain such prior written consent from the parent or legal guardian of the child or from the assigned CA/DDD social worker, if the child is in the custody of DSHS.

- The Contractor shall maintain information concerning individuals in strictest confidence and safeguard all information, electronic and hard copy.

- The Contractor shall assist foster parents to develop strategies, methods and mechanisms to safeguard confidential information in their homes. Confidential

information includes, but is not limited to, ISSPs, health passports, school and mental health records.

3.13 What records shall be retained under BRS contracted services?

In addition to the records required under Minimum Licensing Requirements, the Contractor shall retain and make available the following records:

- **CLIENT RECORDS**

  - Current Legal Authorization (court order, VPA, etc.)
  - Approval for Placement, which includes documented agreement of the start date and BRS service level
  - Information regarding intake, assessment and referral
  - Case planning documents to include ISSP and ISTP
  - Quarterly Reports
  - Cultural relevancy, LEP and ILS plans, when appropriate
  - EPSDT assessment, or equivalent in other states
  - Medical care provided to youth
  - Professional consultation notes, to include who provided consultation
  - Assessment of potential conflict of interest, if the youth is placed in a foster home setting
  - Placement extensions from DSHS
  - Incident Reports involving the youth
  - Health Assessment
  - Program Orientation
  - IBMP
  - ISTP
  - ILS assessment and Plan
  - Copies of Aftercare Service Plans

- **ADMINISTRATIVE RECORDS**

  - ***Child Protective Services Log*** to include all alleged incidences of Child Abuse/Neglect.

  - ***Monthly Census Report***

  - ***Documentation*** of all audits, license review, or contract monitoring, and corrective actions required and action taken.

  - ***Protected Groups Data Collection***

    When collecting this data, the Contractor shall inform staff and clients that: (1) the furnishing of the information is entirely voluntary; (2) the refusal to furnish the data shall not have adverse effects.

- A list of all current staff by position that addresses date of birth, sex, and identified protected group status, including race, Vietnam Era Veteran, Disabled Veteran, and person of disability.

- A list of all clients served that addresses date of birth, sex, and race.

➢ **STAFF RECORDS**

- DSHS criminal history background check approval

- FBI criminal history background check if a Washington State resident for less than 3 years

- Statement acknowledging duty to report child maltreatment

- Academic history and credentials

- Employment and experience history

- Staff training log

- Consultation log

➢ **SUBCONTRACTOR RECORDS** *(if the Contractor receives written approval to subcontract)*

- ***Subcontractor File*** containing the contracts or agreements between the Contractor and the subcontractors for services required by the contract. The file shall also document the qualifications, credentials and criminal history background check for each subcontractor and each person employed by same who have unsupervised access to youth served under the contract.

➢ 4. BRS REQUIRED REPORTS

4.1 Census Reports

4.1.1 How often shall census reports be submitted?

The Contractor shall submit a monthly census report to the Contractor's home region BRS Regional Manager on or before the 5th of each month, which lists the census for the previous month. The monthly census report shall include the following information for all youth residing in each facility:

- Name (optional for private pay)
- Date of birth
- Admission date
- Service level
- Name of social worker contact, DSHS division, region
- Exit date and name of children that have discharged from your program within the last 3 months, and their destination.
- Whether the child is receiving ILS
- Current Location of youth's residence

4.2 Progress Reviews

4.2.1 How often shall cases be reviewed?

- The case shall be reviewed and a report generated at intervals within the specified number of days according to the service category.

  - Initial Reports within 30 days of intake
  - Assessment Services: 30 days
  - Interim Care Services: 60 days
  - On-Going Services: 90 days

- The contractor shall convene the child/family team to review the progress made toward short-term and the permanency goals identified in the ISTP. At a minimum, the following shall be reviewed:

  - Client's strengths and successes
  - Any barriers to movement and eventual discharge
  - Strategies to resolve any barriers
  - Type, frequency and quality of contact with family of origin and/or family resource
  - Primary and alternate permanency goals and progress in identifying and finding a permanent home
  - Service level to which the child is assigned in relation to ISTP accomplishments
  - Educational progress

- Progress in achieving skills for independence for youth 16 years of age or older.
- A determination on whether or not the youth can be served at a lower intensity and less costly level of service.
- Any changes to the ISTP or the IBMP.
- Review all updated reports from outside agencies

4.2.2 What elements must be included in a Progress Report?

The contractor shall prepare a written Progress Report for each youth with input from the child/family team. The Progress Report shall document progress made toward goals identified in the ISTP. The report shall include, at a minimum:

- Identified client's strengths and successes
- Any barriers or challenges that may prevent achievement of goals outlined in the ISTP
- Strategies to address barriers and challenges
- Type, frequency and quality of contact with family of origin and/or family resource
- Primary and alternate permanency goals and progress in identifying and finding a permanent home
- Educational progress
- Progress in achieving skills for independence for youth 16 years of age or older
- Any modifications to the ISTP
- Evaluation of service category assignment including why the service level has or has not changed
- Documentation of decision to continue services past 18th birthday

4.2.3 Who should receive copies of the Progress Report?

The contractor shall distribute copies of the Progress Report to:

- CA/DDD Social Worker
- Parents and/or foster parents
- Others designated by DSHS

4.3 Transition Report

4.3.1 When is the Transition report to be done?

The Contractor shall complete a Youth Transition Report on all youth exiting BRS and send a copy of this report to the CA assigned Social Worker, Regional BRS manager and CA Headquarters BRS manager. This report can be mailed, faxed or E-mailed (report can be E-mailed as long as the youth's CA identification number is only used and not their name). If the Contractor serves youth under the Medically Fragile service level the Transition Report is not required.

4.4 Annual Report

4.4.1 When is the Annual Report due?

The Contractor shall complete an Annual report and mail, Fax or E-mail this report to the CA Regional BRS manager and CA headquarters BRS manager no later than June 30th.

If the Contractor is only serving youth under the Medically Fragile service level the Contractor is only required to complete the average length of stay and transition placement sections of the annual report.

If the Contractor is only serving youth under the Developmentally Disabled (3A,3B, 3C service levels, the Contractor is required to complete all sections of the annual report except the CFARS scores.

➢ 5. DEFINITIONS FOR SERVICE CATEGORIES

5.1 What are the behavior definitions of youth to be served by On-Going Services that are not considered to be medically fragile?

BEHAVIOR DEFINITIONS

Frequency, intensity and duration of client behaviors are defined below. Behaviors that are considered a danger to the child, to others or to the community/tribe *(e.g., fire setting, sexual predation, and suicidal gestures)* must be weighted appropriately and separately in determining the overall risk of the child. These definitions serve as guidelines:

Extreme
a) *Frequency:* behaviors occur several times per day.
b) *Duration:* behaviors have historically occurred for more than 2 years.
c) *Intensity:* individual incidents last over 30 minutes and/or present an extreme danger to self, others and /or property.

Severe
a) *Frequency:* Behaviors occur daily.
b) *Duration:* Behaviors have historically occurred for 1 - 2 years.
c) *Intensity:* Individual incidents last from 15 - 30 minutes and/or present a danger to self, others and/or property.

Serious
a) *Frequency:* Behaviors occur several times per week.
b) *Duration:* Behaviors have historically occurred for 6 - 12 months.
c) *Intensity:* Individual incidents last from 5 - 15 minutes and/or present a considerable risk to self, others and/or property.

Moderate
a) *Frequency:* Behaviors occur one time a week or less.
b) *Duration:* Behaviors have historically occurred 6 months or less.
c) *Intensity:* Individual incidents last less than 5 minutes and/or present a risk to self, others and/or property.

5.2 What are the client definitions for the On-Going Service levels?

5.2.1 BEHAVIORALLY/EMOTIONALLY DISORDERED

It should be recognized that children/youth who are behaviorally/emotionally disordered may also have multiple behavioral problems or core disability characteristics in addition to severe family conflict or dysfunction. In this service level, services should address the elements of the child's behavior which necessitate this level of care. Services must be available to ameliorate, to the extent possible, barriers to the child's reunification with the family. These children often are professionally diagnosed with serious mental health

disturbances, Fetal Alcohol Syndrome, Alcohol Related Neurological Disorder and/or developmental disabilities.
The range of behaviors includes, but is not limited to:

- Impulsive behavior
- Property destruction
- Hearing impaired/deaf
- Self Abusive
- Inability to protect self
- Runaway
- Aggressive assaultive
- Unpredictability
- Sexual acting out
- Encopresis
- Vision Impaired/blind
- Attachment disorder
- Manic
- Obsessive/compulsive
- Social skill deficit
- Physically aggressive
- Enuresis
- Substance abuse
- Fire setting
- Depression
- Risk to community/tribe
- Verbal threats/abuse
- Stealing/theft
- Animal abuse/cruelty
- Eating disorders
- Suicidal
- Delusion
- Non-compliant
- Uncontrollable rage

CATEGORY 1-A EXTREME BEHAVIORS: These children have often been through several failed placement settings, are considered a danger to themselves or other children. These children may also have exited psychiatric treatment facilities and are in continued need of highly structured settings. These children/youth display a range of ***extreme behaviors*** and emotional difficulties and may include SAY youth who are resistant to treatment.

CATEGORY 1-B SEVERE BEHAVIORS: These children have often been through several failed placement settings, are at considerable risk to themselves or other children. These children/youth display a range of ***severe behaviors*** and emotional difficulties.

CATEGORY 1-C SERIOUS BEHAVIORS: These children present very challenging behaviors in a number of areas *(community, family, educational etc.).* Past efforts to intervene have not been successful. Family functioning may contribute to behavioral difficulties. Increased structure will be needed to ensure safety. These children/youth display a range of ***serious behaviors*** and emotional difficulties.

CATEGORY 1-D MODERATE BEHAVIORS: These children present challenging behaviors in a number of areas *(community, family, educational etc.)* Past efforts at intervention have had little success. Family functioning may contribute to behavioral difficulties. These children/youth display a range of ***moderate behaviors*** and emotional difficulties.

5.2.2 SEXUALLY AGGRESSIVE

It should be recognized that children who are sexually aggressive might also have additional behavioral problems, mental health disturbances or developmental disabilities. In this service level, the treatment should address sexually aggressive behavior as the primary behavioral indicator. Many of these children/youth will have experienced sexual

abuse themselves. These children may have been criminally adjudicated for these acts and present a potential risk to the community/tribe where they live.

The range of behaviors includes, but are not limited to:

- Rape
- Incest
- Assaultive
- Inability to connect cause and effect
- Developmentally disabled
- Anti-social behavior
- Prostitution
- Violent sexual acts
- Public masturbation/exposure
- Unpredictability
- Attachment disorder
- Denial
- Adjudicated sexual crimes
- Coercion
- Peeping/voyeurism
- Resistant to treatment
- Mental health problems/diagnosis
- Deviant sexual preoccupation
- Fire setting
- Sexual offenses/non-adjudicated
- Seduction
- Physically aggressive
- Stealing
- Animal abuse/cruelty
- Enuresis/encopresis
- Chemically dependent

CATEGORY 2-A HIGH RISK SAY: These children have a history of and are at high risk to continue displaying a range of sexually aggressive behaviors toward peers and younger children. The level of supervision that is required for the ***high-risk sexually aggressive*** youth is approximately equal to the severe behaviorally disordered designation.

CATEGORY 2-B MODERATE RISK SAY: These children have a history of and are at moderate risk to continue displaying a range of sexually aggressive behaviors toward peers and younger children. The level of supervision that is required for the moderate risk sexually aggressive youth is approximately equal to the severe or serious behaviorally disordered designation.

5.2.3 DEVELOPMENTALLY DISABLED (DD)

It should be recognized that children who are developmentally disabled *(including Fetal Alcohol Syndrome and Alcohol Related Neurological Disorder)* may also have behavioral disabilities, serious physical health impairments and require partial or total personal care. At this service level, the service should address those behavioral disabilities, which pose barriers to the child's ability to remain in the family home or in a less restrictive setting. In addition to developing effective behavioral management strategies for the child, supports and/or training will be provided *(when possible)* which enable family reunification. The degrees of developmental disability that may affect a person are commonly described as: mild, borderline, moderate, severe and profound. The children described in this category may fit any of these. Children may rely on adaptive devices for mobility, communication and self-care.

These children often display a range of behaviors that may include:

- Kicking/hitting
- Stealing
- Non-compliance
- Expressive/receptive language problems
- Property destruction
- Echolalia
- Tourettes syndrome
- Uncontrollable rage
- Low self protection skills
- Frequent tantrums
- Aggression
- Impulsiveness
- Obsessive/compulsive
- Sensory integration problems
- Speech/motor delays
- Physical disabilities
- Limitations in self help skills (toileting, bathing, dressing hygiene, etc.)
- Victims of physical abuse/neglect
- Inability to connect cause and effect
- Lack of impulse control
- Lack of safety skills
- Communication disorders
- Obsessive speech patterns
- Verbally abusive
- Hearing impaired/deaf
- Unpredictability
- Sexual acting out
- Victim of sexual abuse
- Physically assaultive
- Non verbal
- Seizure disorder
- Non compliant
- Vision impaired/blind
- Self-abusive (head banging, biting, hair pulling, mutilation, etc.)

CATEGORY 3-A EXTREMELY BEHAVIORALLY DISTURBED DD CHILDREN: 6 - 17 years of age dually diagnosed with mental health issues and impaired reasoning and intellectual functioning. These children may also have pervasive emotional and ***extreme behavioral*** disturbances resulting in a range of behaviors potentially injurious to self or others.

CATEGORY 3-B SERIOUSLY BEHAVIORALLY DISTURBED DD CHILDREN: 6 - 17 years of age dually diagnosed with developmental disability, mental health issues, and impaired reasoning and intellectual functioning who also have ***serious*** emotional and behavioral disturbances.

CATEGORY 3-C BEHAVIORALLY DISTURBED CHILDREN WITH AUTISM: 6 - 17 years of age who are professionally diagnosed with autism or pervasive developmental disorder and also display a range of serious behaviors and emotional difficulties.

➢ 6. SHORT-TERM/EMERGENT CARE

6.1 What are Short-Term/Emergent Care Services?

The Contractor shall have the ability to provide Short-Term/Emergent Care Services 24 hours a day, seven days a week. Youth entering these programs exhibit a range of behaviors which may include: assaultive/aggressive, self injurious *(e.g., suicidal gesturing, physically reckless, self mutilation, etc.)*, substance abuse, sexually aggressive, property destruction, running away, defiance, fire setting, stealing, eating disorders, difficulty in understanding cause and effect relationships, and serious family conflict. Stabilization/ resolution of behaviors should be seen as the primary focus of service. Clients placed in short-term/emergent service programs shall be provided direct services, information on available community/tribal support, and training focused on maintaining family, cultural and community/tribal connections. Resources will be provided to the client to achieve family reunification whenever possible at this level of service. Close contact with parents, which involves the family in decision-making, should be maintained to the greatest extent possible. The contractor shall include services to all children from 6 - 17 years of age unless otherwise noted in your contract with DSHS for BRS.

Short-Term/Emergent Care Services may include:

- Assessment Services
- Interim Care Services

6.2 What is the goal of Short-Term/Emergent Care Services?

The goal of these services is to provide a more thorough understanding of the individual, family and community factors which contribute to the identified difficulties of a youth and to stabilize or resolve behaviors which require intensive adult attention. Family inclusion in planning and decision making is critical to the success of treatment, referral and reunification efforts.

6.3 How are referrals made for Short-Term/Emergent Care Services?

The contractor is expected to accept all referrals made by CA authorized staff as outlined in regional protocol. CA staff positions with referral authority will vary by region; thus the contractor must consult regional protocol when determining CA authorization status.

6.4 What is the time requirement for beginning Short-Term/Emergent Care Services?

Contractors providing Short-Term/Emergent, Assessment and Interim Care must be able to begin services within four (4) hours of referral. Services shall be available 24 hours per day, 7 days per week.

6.5 How long may Short-Term/Emergent Care Services be provided?

The maximum length of Short-Term/Emergent Care Services is as follows:

- Assessment Services—90 days
- Interim Care Services—180 days

6.6 What are the first steps in providing Short-Term/Emergent Care Services?

- The Contractor shall convene the child/family team to develop a case plan:

  - within 5 days for youth receiving Assessment Services
  - within 15 days for Interim Care Services

6.7 What services shall be provided for each youth under Short-Term/Emergent Care Services?

The contractor shall provide specific services for each youth and their family to address treatment and support needs identified in the youth's ISTP.

6.8 What are the job responsibilities of the contractor's social service staff for Short-Term/Emergent Care Services?

Social service staff shall have the primary responsibility for planning, developing and implementing treatment and support services for clients. Social service staff shall collaborate with DSHS in delivering services to each client, consistent with provider qualifications.

- Arranging for assessments.

- Arranging for individual, group and family counseling.

- Coordinating the provision of the range of assessments and interventions that are appropriate for each client.

- Participating with the family and the local school district in efforts to ensure an appropriate educational plan is in place for the youth.

- Advocating with the local school district to ensure that the youth receives appropriate educational services.

- Coordinating and ensuring inclusion of the child/family team in planning and decision making processes.

- Developing a child specific service plan based on the results of the assessment and treatment activities.

- Ensuring that assessment and treatment activities provided are documented in the individual client file.

- Ensuring that a written assessment of service needs and current level of functioning is provided to DSHS prior to the youth's move to another placement (including back home).

➢ ON-GOING SERVICES

7.1 What is the goal of On-Going Services?

The goal of these services is to stabilize the child's level of functioning and to assist the client in the acquisition of skills and the development of supports which will allow the child to maintain or develop a permanent family connection and to reside in his or her own community with less intensive service needs.

7.2 What is the program description of On-Going Services?

The following is a compilation of characteristic definitions of children to be served within Behavior Rehabilitation Services. A list of possible behaviors/conditions has been included for children requiring therapeutic services through BRS. The list of behaviors/conditions for each category is not intended to be inclusive or exclusive of those that may be encountered during service delivery. Providers will often serve children with combinations of developmental, behavioral and emotional problems and medical conditions at varying levels of intensity. Contractors shall provide services to all children from 6 - 17 years of age unless otherwise noted in your contract with DSHS for BRS.

Omission of specific medical, psychiatric or developmental/behavior disability diagnosis should not be taken to mean that the children to be served do not demonstrate these conditions. These categories are intended to help clarify for providers the population to be served and the range of behaviors that a provider should have the capacity to safely manage while providing effective care and treatment to individual or groups of children and their families. The assignment of children to categories will be made by DSHS based on the frequency, duration and intensity of behaviors as well as the strengths and resources of the family to support the child's success.

Services to establish and maintain the family's involvement with the child and his/her service plan must be provided. These services should increase the capacity of the family resource to ultimately care for the child within the community/tribe. These services will include educational and supportive interventions, as well as developing and teaching effective behavior management strategies for the child. Services should focus on resolving issues which directly impact client functioning and present barriers to the child's ability to remain in the family home. Involvement of the family as full partners in decision making should be maintained whenever possible.

In the absence of an identified permanent family resource for a child, the provider is expected to actively work with the CA/DDD Social Worker and the child to meet DSHS' goal of identifying, recruiting and finalizing a permanent placement for each child in accordance with the child's ISSP.

7.3 How long can a youth be served by On-Going Services?

On-Going Services are limited to 18 months per youth unless prior approval is obtained from the CA Regional Administrator or designee to extend services.

7.4 What reviews, plans and reports are required for On-Going Services that are in addition to the reports required in section 3.13?

- **AFTERCARE SUPPORT PLAN:** The contractor shall develop an aftercare plan in coordination with the child/family team prior to discharge. The plan shall identify community support linkages for the child and family. An aftercare support plan shall be implemented for all youth discharged to a less restrictive setting.

- **DISCHARGE SUMMARY:** The contractor shall submit a written discharge summary within 14 days following discharge to the CA/DDD Social Worker and the child/family team. The summary shall be in accordance with the requirements stated in this handbook.

7.5 Are Aftercare Services required for youth upon discharged from the program?

The Contractor shall provide up to 6 months of aftercare services upon documented request by the DSHS Social Worker, unless the child is moving into another BRS program.

The Contractor shall submit a detailed service plan and budget for each client who will receive aftercare services. All aftercare services must be approved in writing by DSHS prior to delivery of services.

The Contractor shall review the safety plan with the youth's CA/DDD Social Worker, parents, individuals who have regular contact with the child, treatment providers, and others who have a role in monitoring the youth's safety.

➢ 8. IN-HOME SERVICES

Contractors who provide in-home services under a Behavior Rehabilitation Services contract shall adhere to the following expectations as well as all other BRS requirements, policies and procedures set forth in the contract and this handbook.

8.1 What are In-Home service expectations?

- In-home services may be the sole mode of providing services, or may be provided in conjunction with out-of-home placement. In-home services can be provided in the child's family home or in the home of the child's family resource.

- The contractor shall support families as the primary decision-makers for their children, including them as members of the service planning team and empowering them to identify the goals to be achieved through services.

- The contractor shall complete an in-home assessment of family strengths and needs within the first two (2) weeks of service to the family.

- The contractor's staff shall model the skills identified in the service plan and mentor family members as they master these skills.

- Services to families shall be individualized to meet the family's identified needs and shall be responsive to the family's culture and ethnicity.

- The contractor shall provide staff needed to support the service plan, to include but not be limited to: social service staff, case manager, clinical consultant, case aides, and 24 hour on-call staff who are familiar with the family and the issues.

- Consistent with service plan goals, the contractor must assist families in meeting their basic needs, both through use of existing community resources and by providing concrete support, as needed. The contractor is responsible for any cost that may be charged by community resources or costs incurred in providing concrete supports. These costs are included in the rate.

8.2 How often shall respite care be provided for family or the child's family resource?

- Respite care shall be among the range of service options and intervention strategies available at this level of care. Respite may be offered either in the child's home *(allowing the child to stay and the caretaker to leave)* or in the community *(allowing the caretaker to stay and child to leave).* The decision to offer respite services shall be made in conjunction with the child/family team and shall be based on the assessed needs of the client.

- The contractor shall offer and be able to provide a minimum of 2 days per month of respite care, which may be accumulated to a maximum of 6 days per quarter, if consistent with the child's service plan. *(A day is defined as an 8-hour block of time, but may include additional hours of care, up to 24 hours, when respite includes an overnight stay.)*

8.3 What shall be the focus of in-home services?

In addition to the overall BRS goals for behavior stabilization and treatment of present issues, in-home services shall focus on the following:

- Minimize the disruption caused by a residential move, or avoid a residential move, while providing a high level of services to the child and family.
- Ensure the safety of the child and family throughout planning and service delivery.
- Identify and build upon the individual strengths of each family member.
- Strengthen family members' connections to supports – both within the family and in the community – which will endure once DSHS services have ended.
- Teach family members the skills needed to manage the presenting issues.
- Assist family members in identifying and using community resources.
- Provide opportunities for all family members to experience success in dealing with the issues.

8.4 What support services shall be provided for caregivers that are in addition to the support services that are required in sections 1.15 and 2.5?

- The contractor shall offer family members the opportunity to participate in training that is relevant to the needs of their child.
- The contractor must visit the family's home at least weekly as part of the overall service plan. If the service plan calls for decreasing support in preparation for ending services, steps and timelines must be specifically identified in the ISTP.

➢ 9. TREATMENT FOSTER CARE (TFC)

Child Placing Agency contractors who provide treatment foster care homes under a Behavior Rehabilitation Services (BRS) contract shall adhere to the following expectations as well as all other BRS requirements, policies and procedures set forth in the contract and this handbook.

9.1 How many children can reside in a treatment foster home?

The contractor shall ensure:

- Treatment foster homes are limited to no more than 6 children, per the Minimum Licensing Requirements.

- Each treatment foster home must operate within the capacity stated in its license.

- Treatment foster homes have no more than 4 of their own minor children or non-TFC children, in the home; and

- No more than 3 TFC foster children are placed in a foster home at one time, unless a sibling group is to be placed together or there is a therapeutic basis for the placement of more than 3 children in the home. All placements in excess of three TFC children must have the approval of the CA Regional Administrator, or designee.

- Within the above parameters, foster families must have no more total children in the home than they can demonstrate the ability to manage successfully -- based on history, training, number of adults in the home, agency support, and physical space.

9.2 How often shall respite care be provided for treatment foster parents?

- Respite care shall be among the range of service options and intervention strategies available at this level of care. Respite may be offered either in the child's home *(allowing the child to stay and the caretaker to leave)* or in the community *(allowing the caretaker to stay and child to leave).* The determination to offer respite services shall be made in conjunction with the child/family team and shall be based on the assessed needs of the client.

- The contractor shall offer and be able to provide a minimum of 2 days per month respite care to foster parents serving children under the BRS contract. *(A day is defined as an 8-hour block of time, but may include additional hours of care, up to 24 hours, when respite includes an overnight stay.).* Respite may be accumulated up to 6 days per quarter, if consistent with the child's service plan.

9.3 Are foster parents required to attend training?

- Foster parents should complete Foster Parent Pre-service Training and PRIDE *(or an equivalent training offered or approved by DLR)* prior to serving children through the BRS contract. However, if PRIDE training is not available prior to placement, the contractor shall make a determination that foster parents have the skills and understanding needed to serve case specific presenting problems of children being placed. The Contractor shall document what prior training, education and experience have prepared the foster parents to provide care prior to completing PRIDE.

- Regardless of prior training or experience, foster parents must complete PRIDE training within two (2) years of licensing.

- The contractor shall develop, monitor, and annually assess training plans for treatment foster parents. Foster parents must obtain 30 hours of training annually. Topics offered maybe based on foster parents' needs for skill development, and the issues of the children they are serving. Prior to placing a sexually aggressive (SAY) or physically aggressive youth (PAY) with a foster parent (s) that foster parent (s) shall have specific training to address the safety and supervision of SAY or PAY youth. This training can be through DLR or the Contractor and should be incorporated into the annual training requirements of foster parents based on the youth residing in their home.

- The contractor shall provide monthly meetings for informal support and training for foster parents.

9.4 How often shall foster parents skills and abilities be evaluated?

The contractor shall conduct annual evaluations of foster parents to assess their skill and ability to provide and support services for children in their care. If foster parent needs are identified, the contractor shall plan with the foster parents for amelioration; the contractor shall follow up with the foster parents at regular intervals, at least quarterly, and support them in improving their skills and abilities. A copy of the evaluation shall be kept in the foster parent file.

9.5 What support services shall be provided for foster parents?

- The contractor shall initiate and participate in weekly treatment/support meetings with the foster family. At least one meeting per month must happen in the foster home.

- The contractor shall provide the staff needed to support the service plan and the child's success in the foster home, which may include but not be limited to: case manager, clinical consultant, case aides and 24 hour on-call staff who are familiar with the case.

9.6 What are the expectations for Treatment Foster Homes that provide care under the contractor's BRS contract?

1. Foster parents shall serve as the primary service providers for the children placed in their homes, assuming direct responsibility for daily management of the child's emotional and/or behavioral problems.

2. Foster parents shall model appropriate problem-solving, communication, conflict resolution, and other social skills.

3. Foster parents shall act as members of the service team, participating in the development and implementation of the service plan.

4. Foster parents shall maintain adequate records and documentation of each child's activities and behavior to assist the agency and the department in planning for the child.

5. Foster parents shall maintain records of all medical appointments and services provided to the child, including all pertinent information regarding medications.

6. Foster parents shall maintain confidential information about each child in a secure manner so that it is not accessible to children or unauthorized adults.

7. At least one parent in each foster home must be available at all times to respond to the child's needs, unless other arrangements have been specifically made with the agency and DSHS has approved the arrangement.

8. Children in treatment foster care shall not be enrolled in child day care, unless enrollment is consistent with the child's therapeutic needs.

9. With the support of the contracting agency, foster parents shall enroll the child in school and participate in educational planning and school meetings, and shall advocate for the child in the school system.

10. Foster parents should complete Pre-service Training and PRIDE *(or equivalent training as offered or approved by DLR)* before serving children under the BRS contract. Foster parents shall participate in 30 hours of training annually.

11. Foster parents shall participate in appropriate support activities offered by the contracting agency.

12. Foster parents shall work with whatever family resources are available for a child, to facilitate reunification, visitation, and/or permanency planning.

13. Foster parents shall provide transportation for the child, as needed, to school, appointments, activities, and other day-to-day appointments and/or activities.

9.7 What steps shall be completed upon a youth's admission that is in addition to section 2.3?

- **PROGRAM ORIENTATION:** Provide an orientation within 8 hours of the youth's placement in the TFC home for the youth, which shall include but not be limited to:

  - ✓ Physical layout of the home including emergency evacuation route
  - ✓ Control of contraband policy
  - ✓ Client visitation policy
  - ✓ Daily program and activities

9.8 What supervision resources are required?

The contractor shall have available the capacity to offer a variety of safety/supervision strategies as appropriate for a youth's assessed needs. These resources may include but are not limited to:

- ✓ Individual sleeping room
- ✓ Additional supervisory staff (including in-home aides)
- ✓ Respite care

9.9 What actions must be taken to avoid any conflict of interest in placing a child?

- The Contractor shall ensure that an assessment of potential conflict of interest occurs before the Contractor places any child in an out-of-home placement. The assessment shall include asking any adult living in the out-of-home placement whether a conflict of interest of the following nature exists. The Contractor must also require that all adults in the home report any conflict of interest that occurs after the child is placed by the following workday.

- A conflict of interest exists when:

  - An adult in the home conducts or has conducted an investigation, as a result of the adult's employment, of an allegation of abuse or neglect of the child; or

  - The child is or has been, or is likely to be a witness against an adult in the home in any pending legal action or claim against the state involving:

    - ✓ An allegation of abuse or neglect of the child or sibling of the child; or

    - ✓ A claim of damages for wrongful interference with the parent-child relationship between the child and his or her biological parent.

- For purposes of this provision, "investigation" means the exercise of professional judgment in the review of allegations of abuse or neglect by (a) law enforcement personnel; (b) persons employed by, or under contract with, the state; (c) persons

licensed to practice law and their employees; and (d) mental health professionals as defined in chapter 71.05 RCW.

- The Contractor shall not place or allow a child to remain in a specific out-of-home placement, when there is a conflict of interest on the part of any adult residing in the home, in which the child is to be or has been placed.

➢ 10.FACILITY BASED CARE

Contractors who provide facility/residential based services under a Behavior Rehabilitation Services contract shall adhere to the following expectations as well as all other BRS requirements, policies and procedures set forth in the contract and this handbook.

10.1 What steps shall be completed upon a youth's admission that are in addition to section 2.3?

- **PROGRAM ORIENTATION:** Provide an orientation within 8 hours of the youths admission to the program for the youth, which shall include but not be limited to:

  - Physical layout of the facility including emergency evacuation route
  - Control of contraband policy
  - Client visitation policy
  - Daily program and activities at the facility
  - Behavioral expectations
  - Method for contacting the DSHS social worker

10.2 What supervision resources are required?

The contractor shall have available the capacity to offer a variety of safety/supervision strategies as appropriate for a youth's assessed needs. These resources may include but are not limited to:

- Individual sleeping room
- Additional supervisory staff
- Respite care

10.3 What structured activities should be provided in facility-based programs?

Activities to increase skills, learning and confidence so youth obtain the maximum benefit from this level of care. Activities shall include but are not limited to:

- Anger Management education
- Drug/alcohol education
- Health education
- Social skill training
- Work/vocational activities
- Physical recreation
- Other recreation

10.4 What are the minimum staff-to-child ratios, which must be maintained for residential facilities?

- The Contractor shall maintain, *at a minimum*, staff-to-child ratios in accordance with "Ratio of Caretaker Adults to Child" chart *(see appendix)*.

- Health and safety of children shall always be the first concern of the Contractor. It is the Contractor's duty and responsibility to provide adequate staff to ensure health and safety of children. The Contractor shall provide additional staff if the health and safety of children warrants such action.

10.5 What are the required staffing requirements for Contractors serving youth in residential settings of more than six youth?

The Contractor shall maintain the following staffing requirement, with the exception of Medically Fragile Services. Staffing qualifications for Medically Fragile Services are stated in chapter 10, "Medically Fragile Services" of this handbook.

In addition to the job qualifications stated in section 3.5, the Contractor shall maintain the following staffing qualifications. The Contractor shall notify DSHS in writing if staffing qualifications fall below the following levels:

a. **PROGRAM DIRECTOR:** Responsibilities include supervising staff, providing overall direction to the program and ensuring that contractual requirements and intents are met.

Minimum qualifications are a Bachelor's Degree with major study in psychology, sociology, social work, social sciences, or a closely allied field, and two years experience in the supervision and management of a residential or treatment program for adolescents.

b. **CASE MANAGEMENT STAFF:** Responsibilities include, but are not limited to, development of individual service and treatment plans and leadership of child care staff in providing appropriate treatment for the children.

c. **CHILDCARE STAFF:** Responsibilities include, but are not limited to, assisting social service staff in addressing behavioral and emotional problems per the treatment plan.

No less than 50% of the child care staff in a facility must have a Bachelor's Degree. Combinations of formal education and experience working with troubled children may be substituted for a Bachelor's Degree.

10.6 What are the required staffing requirements for Contractors serving youth in residential settings of six or fewer youth?

In addition to the job qualifications stated in section 3.5, the Contractor shall maintain the following staffing qualifications; Contractors serving six (6) or fewer children shall meet or exceed the following staffing qualifications:

a. **PROGRAM DIRECTOR:** Responsibilities include supervising staff, providing overall direction to the program, ensuring that appropriate professional oversight is provided to the program, and assuring that contractual requirements and intents are met.

Minimum qualifications are a Bachelor's Degree with major study in psychology, sociology, social work, social sciences, or a closely allied field, **AND**

Two (2) years experience working in a residential program for adolescents;

OR

Five (5) years experience working in a residential care program or foster home which included implementing service plans, with at least two (2) years of which included working under the supervision of a clinician.

b. **CASE MANAGEMENT STAFF:** Responsibilities include, but are not limited to, development of individual service and treatment plans and leadership of child care staff in providing appropriate treatment for the children.

Social Service Staff shall have a Master's Degree in social work or a closely allied field. Experience may be substituted for educational requirements upon DSHS written approval.

c. **CHILD CARE STAFF:** Responsibilities include working with social service staff in providing services and supervision as identified in the IBMP.

Minimum qualifications are a high school diploma or GED.

d. **MASTER'S LEVEL OVERSIGHT:** In addition to the staffing qualifications listed in this section, the Contractor's program shall have master's level oversight. This requirement may be met through a master's level program director or social service staff or by subcontracting with a consultant. The Contractor shall obtain written approval from DSHS for a consultant who provides program oversight.

➢ 11.MEDICALLY FRAGILE SERVICES

11.1 What is the program description for Medically Fragile Services?

Medically Fragile Services are for children with medically intensive needs who require more individual and continuous care than is available from an intermittent visiting nurse. Services are to be supervised by a Registered Nurse (RN) and provided in a licensed foster home, group home, or a licensed facility for severely and multiply handicapped children.

Services to medically fragile children should include the family and extended family in the care and support of each child to the degree that is possible. Coordination with a wide range of disciplines and service providers is expected.

11.2 What is the goal of Medically Fragile Services?

The goal of Medically Fragile Services is to provide transitional services for children who require complex medical care for a condition of such severity and/or complexity that skilled nursing is required. Most children will be moved to a less intensive, more normalized living arrangement at the earliest opportunity permitted by the primary physician. In those instances where death is imminent, the goal shall be to provide comfort and care until death.

11.3 What are the client definitions for Medically Fragile Services?

Children birth through 17 years of age that require complex medical care for a condition of such severity and/or complexity that skilled nursing care is required. This includes children with medically intensive needs that require more individual and continuous care than is available from an intermittent visiting nurse. Conditions include, but are not limited to:

- Mechanical Ventilation Tracheotomy
- Peritoneal Dialysis

Also includes medically fragile children who have care needs that are very labor intensive and such care must be supervised by a RN. Conditions include, but are not limited to:

- Brain tumor causing seizures
- Breathing assistance
- Nephritic syndrome
- Bone cancer
- Kidney transplant
- Severe injury
- Severe brain damage
- Tube feeding
- Sickle cell anemia
- Comatose/semi-comatose
- Life threatening medical/developmental conditions

11.4 What are the first steps in providing Medically Fragile Services for each youth?

- **MULTI-DISCIPLINARY PLAN:** A multi-disciplinary plan of care shall be developed as provided by law to meet the child's needs.

11.5 What services shall be provided for youth in care?

- The Contractor shall provide medical staff as necessary to meet the safety and medical needs of youth in care.
- The Contractor shall provide or arrange for the provision of an Individual Educational Plan (IEP) suited to the unique needs of each youth in care.

11.6 What staff qualifications are required for Medically Fragile Services?

In addition to the qualifications set forth in the BRS Contract, the Contractor shall adhere to the following:

- **ALL STAFF** shall have the necessary license/registration/certification as required by law and DSHS policy.

- **NURSING STAFF** shall be licensed as an Advanced Registered Nurse Practitioner, (ARNP), Registered Nurse (RN) or Licensed Practical Nurse (LPN).

- 50% of ***direct childcare staff*** shall have a bachelor degree, a nursing degree or have a combination of education and experience commensurate with these qualifications. Remaining direct care staff shall include registered home health aides, *(which includes some certified nursing assistants)*.

- **SOCIAL SERVICE STAFF** shall have a master's degree in social work or closely allied field or a bachelor degree in social work or closely allied field with master's level supervision. Master level supervision shall be provided at a rate of 2 hours per week for bachelor level social service staff.

- **PROGRAM COORDINATOR** shall have a bachelor degree in social science or closely allied field with two years experience and management in a group care program, medically intensive service program, or equivalent.

- **COUNSELORS** shall have a master's degree in social work or closely allied field and one year experience or a bachelor degree and two years experience.

11.7 Can other sources of funds be utilized for nursing services?

- Nursing services may be funded by:

  - Medical Assistance Administration - Medicaid Private Duty Nursing (PDN) program for medically intensive nursing
  - Department of Developmental Disabilities, private insurance, military insurance or other family resources.

  However, the Contractor must not bill DSHS for services rendered under this Contract when the Contractor is being paid by another funding source which would result in duplicate billing for the same service.

- When space is available, the Contractor shall not deny services or placement to a youth who has been referred by DSHS who meets the medically fragile service definition.

APPENDIX A
DEFINITIONS

The words and phrases listed below, as used in this Contract, and the Behavior Rehabilitation Services Contractor's Handbook, shall each have the following definitions:

Abuse of Client: The injury, sexual abuse or exploitation, negligent treatment or maltreatment of a client by any person under circumstances which indicate that the client's health, welfare or safety is harmed thereby.

Authorized: Approved by DSHS Social Worker as evidenced by receipt of a Social Services Payment System (SSPS) notice or other written notice.

BRS: Behavior Rehabilitation Services

CA: The Children's Administration, which is an administration under DSHS.

Central Contract Services: The DSHS Office of Legal Affairs, Central Contract Services, or successor section or office.

Child and Family Team: A group of professionals and others providing services to the child and family, including family members and the DSHS Social Worker, who are convened regularly by the Contractor to evaluate progress, review the effectiveness of the service plan, and build on the strengths of family members.

Child Protective Team (CPT): A group of community professionals with varied expertise convened by DSHS to review DCFS cases at critical decision-making points to strengthen planning and provide expert consultation.

Child, ***Youth***, and ***Client:*** Are used interchangeably throughout this contract and shall mean any un-emancipated individual who is under the chronological age of 18 years. Youth enrolled in high school or a high school completion program are included in this definition until completion of high school or age 21, whichever occurs first.

COA: Council on Accreditation

Consultant: A person who is qualified by credential, background, or experience to assist in assessing, evaluating, counseling, or treating the client, and who provides technical, clinical, practical or other relevant assistance to the Contractor in the assessment evaluation, counseling, or treatment of a client.

Contract: The entire written agreement between DSHS and the Contractor, including any Exhibits, documents, and materials attached or incorporated by reference.

Contracting Officer: The Contracts Administrator, or successor, of Central Contract Services or successor section or office.

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Contractor: The individual or entity performing services pursuant to the Contract and includes the Contractor's owners, members, officers, directors, partners, employees and/or agents unless otherwise stated in the Contract. For purposes of any permitted Subcontract, "Contractor" includes any Subcontractor and its owners, members, officers, directors, partners, employees and/or agents.

CPS: Child Protective Services

CWS: Child Welfare Services

DCFS: The Division of Children and Family Services, which is a division under CA.

DDD: The Division of Developmental Disabilities, which is a division within DSHS.

DLR: the Division of Licensed Resources, which is a division under CA.

DSHS or ***the department*** or ***the Department:*** the Department of Social and Health Services of the State of Washington and its employees and authorized agents.

DSHS or ***DCFS Social Worker:*** In providing services to Native American children, whenever the term DSHS or DCFS Social Worker is used, the term shall also mean the child's tribe and Tribal Social Worker.

EPSDT: Early Periodic Screening Diagnosis and Treatment, which is administered in Washington State as the Healthy Kids Program.

Family or ***Family Resource:*** The biological or adoptive parents, relatives, Tribe, or other on-going significant support people, or past, present and future foster parents who remain consistently involved in the treatment and support of a child.

FRS: Family Reconciliation Services

Handbook: The Behavior Rehabilitation Services Contractor Handbook

Home Region: The DSHS region in which the Contractor's headquarters is located.

IBMP: The Individual Behavior Management Plan

IEP: Individual Education Plan

Incident: a disruption in normal routine of the home as a result of a conflict between youth, youth and staff, or as a result of an external disturbance.

ISSP: The Individual Service and Safety Plan

ISTP: The BRS Individual Service and Treatment Plan

APPENDIX A
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ILS: Independent Living Skills

LEP: Limited English Proficiency

LICWAC: Local Indian Child Welfare Advisory Committee

Personal Information: Information identifiable to any person, including but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver license numbers, other identifying numbers, and any financial identifiers.

RCW: Revised Code of Washington. All references in the Contract to RCW chapters or sections shall include any successor, amended, or replacement stature.

Regional Administrator: The Regional Administrator of the administration, DCFS or DDD, that has primary responsibility for that client.

Regulation: Any federal, state, or local regulation, rule or ordinance.

Staffings: Formal or informal meetings of two or more DCFS or professional staff, consultants, parents, or others to review, discuss, or make decisions concerning a client or case.

Subcontract: A separate contract between the Contractor and an individual or entity *("Subcontractor")* to perform all or a portion of the duties and obligations that the Contractor is obligated to perform pursuant to the Contract.

TFC: Treatment Foster Care, also known as Therapeutic Foster Care.

WAC: The Washington Administrative Code. All references in the Contract to WAC chapters or sections shall include any successor, amended, or replacement regulation.

APPENDIX B
RATIO OF CARETAKER ADULTS TO CHILD

(To be Provided during Regional Contract Negotiations)

APPENDIX C
FAMILY CENTERED PRACTICE

INTRODUCTION

The Division of Children and Family Services (DCFS) created this document to describe our family-centered approach to child welfare services, and the intended benefits and outcomes of these services. Family-centered child welfare practices tailor services to individual families, and respect each child's right to basic safety as well as each child's need for a permanent family. Family-centered practices demonstrate our beliefs about how to be most effective with people in the helping process, and allow greater respect for differences in family styles, cultures and communities.

We are working to develop the capability to consistently serve children and families in this manner. With the support of Washington's citizens, we envision the implementation of family centered child welfare practices developing over time; guided by the principles of the Family Policy Initiative and assisted by new commitments of resources for services and supports to children and families.

The welfare of Washington's children and families is a shared responsibility. We believe that the desired benefits of our practice model will be fully achievable only by working collaboratively with our government and community partners.

Our practice model will remain open to periodic revision in response to the needs, expectations and requirements of the families and communities we serve.

ELEMENTS OF THE PRACTICE MODEL

PRACTICE PRINCIPLES
Standards and beliefs that DCFS workers apply to their practice with agency clients. Practice principles guide agency workers and management activities aimed at achieving desired benefits and outcomes.

BENEFITS
Advantages, or things of value, we desire for children, parents, families and communities as a result of DCFS activities.

INTERVENTION STRATEGIES
Intervention strategies are specific actions that DCFS workers take in their practice with clients. They operationalize the DCFS practice principles.

PRACTICE OUTCOMES
Measurable worker outcomes that are defined in behavioral terms. Practice outcomes delineate components of the intervention strategies.

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CLIENT OUTCOMES
Measurable and observable results of DCFS involvement with individual children, parents, families and communities.

PRACTICE PRINCIPLES

- Child safety must always be promoted while actively assisting the preservation of family connections.

- There is an intrinsic value and human worth in every family .... a fact which obligates society to attempt to enable, empower, and preserve families.

- Families and individual members are most likely to resolve issues of concern by building on their strengths.

- Every child deserves to live in a family which provides basic safety, nurturing and a commitment to permanent caretaking.

- The cultural and ethnic roots of the family are a valuable part of its identity. In order to understand and communicate with the family, cultural sensitivity must be a primary feature of service delivery.

- Children's need for safe and permanent family caretaking can be met by providing appropriate and adequate resources in a timely and effective manner.

- Family-centered approaches facilitate planned, appropriate placement when necessary, based on sound information about the needs of the child.

- Family-centered services offer the best hope of breaking the cycle of hopelessness and helplessness that engulfs many families.

- The first and greatest investment of public resources should be made in the care and treatment of children in their own homes and communities.

- Intervention into the life of children and families should ideally offer as much service as necessary to achieve intended goals, and no more.

- The rights to privacy and confidentiality must be treated with respect when assisting children and families.

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DESIRED BENEFITS OF DCFS SERVICES

BENEFITS FOR FAMILIES

Families are:

- Supported in their efforts to nurture and protect their children and youth.
- Listened to and communicated with in an open and direct way.
- Accepted and honored with their own definitions of membership and cultural identity.
- Helped to identify their problems, strengths and solutions.
- Acknowledged and supported with their own problem definitions and chosen solutions, whenever possible.
- Offered appropriate, accessible and culturally relevant resources.
- Helped to access needed concrete services.
- Offered out-of-home care as a last resort if a child or youth's safety cannot be ensured through the provision of in-home services.
- Actively assisted in maintaining connections with their children and youth in out-of-home care.
- Reunited with their children and youth as soon as their safety can be assured.
- Helped to build linkages with kinship networks and community support networks.

BENEFITS FOR PARENTS

As family members, parents receive the benefits for families listed above. In addition, parents are:

- Helped to strengthen their ability to nurture and protect their children.
- Engaged in the identification of their own strengths and needs.

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- Confronted regarding their behavior, while the positive motives that sometimes underlie abusive behavior are acknowledged.
- Assisted in maintaining and strengthening their attachment to their children and youth.
- Aided in improving relationships with their children and youth.
- Involved in decision-making regarding their children and youth in out of home care.
- Offered support in resolving loss.

BENEFITS FOR CHILDREN AND YOUTH

As family members, children and youth receive the benefits for families listed above. In addition, children and youth are:

- Kept safe from serious abuse and neglect by their parents or other adult caretakers.
- Aided in improving relationships with their parents.
- Assisted in maintaining their cultural identities.
- Assured of having their basic needs met in out-of-home care.
- Helped in maintaining continuity in family connections when in out-of-home care.
- Provided with a timely resolution to separation from their families.
- Offered a stable placement in foster care, with their siblings, and in their home community.
- Helped in overcoming the trauma of child abuse and neglect, resolving grief and loss and integrating the multiple families who have been involved in their lives.
- Provided with a family that is committed to them, with the legal authority for permanent caretaking.
- Adequately prepared for independent living, when leaving foster care as legal adults.

BENEFITS FOR COMMUNITIES

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Communities are provided with culturally relevant and community-based services that protect children and youth and strengthen families. In addition, communities are:

- Educated regarding DCFS' mission, goals, services and intake criteria.
- Provided with licensing and monitoring for day care homes and centers, foster care homes and group care homes.
- Offered collaborative problem-solving and decision-making to address child welfare issues.
- Involved as partners in the planning and development of local service systems.
- Provided quick, open and honest responses to concerns.

INTERVENTION STRATEGIES

INTERVENTION STRATEGY #1:

FAMILY ASSESSMENTS ARE CONDUCTED WITH EACH FAMILY

Practice Outcomes:

- A non-judgmental attitude, respect, active listening skills, cultural sensitivity and an awareness of power differences are demonstrated with the family.
- Child safety risk and protective factors and family issues are identified, discussed and prioritized with the family.
- Assessment begins with the first family contact, and continues throughout agency involvement with the family.
- Family member strengths and needs are assessed in a social/cultural systems context.
- Assessment information and observations are openly shared with the family.

INTERVENTION STRATEGY #2:

SERVICE PLANS ARE BASED ON CONTRACTS OR AGREEMENTS WHICH HAVE BEEN DEVELOPED WITH EACH FAMILY

Practice Outcomes:

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- Families actively participate and share in service planning.

- Service plans divide long-term goals into short-term behaviorally specific objectives that are measurable and achievable.

- Families participate in the periodic evaluation of progress on the attainment of service goals and objectives.

- Expectations, incentives and consequences outlined in service contracts are realistic and appropriate to the family's strengths and needs.

- Service plans are based on an appraisal of family needs and service options with family members.

- Services are matched to the family's needs and capabilities. Planning is focused first on the family's highest priority needs.

INTERVENTION STRATEGY #3:

COURT ORDERED SERVICES ARE SOUGHT FOR CHILDREN WHEN PARENTS ARE UNABLE OR UNWILLING TO VOLUNTARILY PROVIDE FOR THEIR BASIC HEALTH, SAFETY OR WELFARE

Practice Outcomes:

- Removal of an abusing parent or other party is sought when the child has a non-abusing parent who is willing and capable of providing protection in the home.

- Non-custodial parents are notified of juvenile court proceedings, and are offered the opportunity to provide care for their biological children, when placement is necessary.

- Recommendations for court ordered service plans clearly state requirements for plan completion in terms of behaviorally specific objectives and desired results.

INTERVENTION STRATEGY #4:

SERVICES ARE COORDINATED AND THE FAMILY IS LINKED WITH RESOURCES NECESSARY TO IMPROVE FUNCTIONING AND RESOLVE ISSUES OF CONCERN

Practice Outcomes:

- Each family's support network, including relatives, friends, other lay and professional helpers are involved to help resolve current issues of concern.

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- Appropriate family authority over service provision is encouraged. Professional helping supports the parenting role whenever possible, instead of supplanting parental authority and responsibility *(e.g. Allowing parents to use clothing vouchers to purchase clothes their children need when entering foster care).*

- Frequent communication and coordination is maintained with service providers and other persons involved in the family's service plan. Family member's rights to privacy and confidentiality are respected.

- Team approaches to consultation, case planning and decision making are used. Family members are included as key participants.

- Frequent case progress/planning reviews are conducted with the family.

- Advocacy is provided with key systems such as public assistance, housing, medical and educational service providers.

- Case planning is outcome oriented, with clear definitions of what services will accomplish.

- "Due diligence" is exercised locating and contacting extended family members for potential support in the resolution of family issues.

INTERVENTION STRATEGY #5:

IN-HOME STRATEGIES TO SAFELY MAINTAIN FAMILY INTEGRITY ARE THOROUGHLY EXPLORED WITH THE FAMILY

Practice Outcomes:

- Community and support network resources to promote family preservation and family reunification are identified and reviewed with the family.

- Emergency services are offered in a way that promotes capability instead of family dependence *(e.g. housing, financial, medical, utilities, clothing, food).*

- One or more culturally relevant community support services are offered to strengthen family functioning *(e.g. parent aides, education, support groups, treatment services, home visiting services).*

- In-home crisis intervention is offered to eligible families to prevent the removal of children.

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- Families are offered respite care as an alternative to giving the care of their children over to foster care.

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INTERVENTION STRATEGY #6:

FAMILY CONTINUITY IS MAINTAINED FOR CHILDREN WHO ARE TEMPORARILY PLACED IN OUT-OF-HOME CARE

Practice Outcomes:

- The family is encouraged to participate in the selection of the child's placement resource to the extent possible.

- The service plan is reviewed by a *team (including family and members of the family's support network)* before non-emergent placements, or as soon as possible after emergency placements.

- Frequent communication is maintained with foster parents/relative caretakers. Care providers are supported and involved as team members.

- Relatives who at first could not be engaged are later re-contacted for updates on permanency planning, and to encourage beneficial involvement.

- Placements with siblings, selection of foster homes close to natural family, and placement with former foster parents for children who must return to foster care are offered to maintain stability in the lives of foster children.

INTERVENTION STRATEGY #7:

INTENSIVE SERVICES AND CHILD VISITATION ARE OFFERED TO PARENTS TO FACILITATE TIMELY AND SUCCESSFUL REUNIFICATION

Practice Outcomes:

- Parents and children are offered needed services in order to provide the best possible opportunity for the timely resolution of issues preventing safe and lasting reunification.

- Visits between parents and children in placement are frequent and can be offered to parents outside of normal working hours. Parents can be assisted with transportation needs.

- Visits can be combined with parent support/education opportunities.

- Visiting plans are carefully monitored to remove agency barriers, empower parents, and improve the quality of parent/child interactions during visitation.

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INTERVENTION STRATEGY #8:

CONCURRENT PLANNING IS EMPLOYED TO PROMOTE EARLY PERMANENCY WHEN FAMILY REUNIFICATION IS LIKELY FOR CHILDREN IN FOSTER CARE

Practice Outcomes:

- The likelihood for long-term foster care is evaluated within the first 30 to 90 days of placement to determine the need for concurrent planning.

- The service plan clearly outlines the necessary conditions for reunification, the probable time-line for reunification efforts, and the alternative plan for permanency.

- Early case transitions between assessment and permanency planning minimize permanency planning delays.

- Transitions between birth families, foster families and adoptive families are managed with careful attention to continuity.

- Children are matched with families who offer a permanent commitment to caretaking, as early as possible. Foster-adopt/permanency planning homes are used when appropriate, based on the likelihood of successful reunification.

- The decision to pursue an alternative to reunification is openly discussed with the family and its support network. The alternative permanency plan is developed with the family's participation.

- Family members and their support network are encouraged to remain actively involved in service planning. Members who initially could not be engaged are re-contacted, for purposes of reviewing progress toward the permanency plan and encouraging appropriate involvement.

- When children are not in the home where they will stay, progressively longer visits are provided with the permanent family placement to help children adjust to the alternative family.

- Offering necessary services and clearly documenting progress enables an accurate assessment of parental strengths/limitations and children's special needs.

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INTERVENTION STRATEGY #9:

PERMANENCY PLANNING FINALIZATION IS EXPEDITED

Practice Outcomes:

- Early legal agreement is reached about the sufficiency of "reasonable efforts' and the need for an alternative permanency plan, based on: prevention and/or reunification service provision, prescriptive contracting/dispositional planning and clear case documentation.

- Parental separation and *loss issues are* addressed as a necessary part of permanency planning for the child.

- Open adoption and other options to maintain connections between children and their birth families are used when the child's permanency and safety will not be jeopardized.

- Birth, foster and adoptive families are encouraged to participate in the creation of Life Story Books, goodbye letters and visits, and the collection of family mementos and pictures, to help maintain continuity for the child.

- Extended family resources have been identified, prepared and strengthened whenever possible, prior to the termination of parental rights.

- Necessary home-study, paper processing and legal work has been completed quickly to finalize adoption/legal guardianship.

- Use of adoption exchanges, adoption support, and post-placement services facilitate timely and successful adoptions.

INVENTION STRATEGY #10:

INDEPENDENT LIVING PREPARATION IS PROVIDED FOR YOUTH WHO PLAN TO LEAVE FOSTER CARE AS EMANCIPATED MINORS OR ADULTS

Practice Outcomes:

- Family members, foster parents and other adults who have been, or are currently, significant in the youth's life are encouraged to become involved in independent living planning.

- The independent living plan transitions youth from foster care services to inter-dependent living, supported within a formal or informal network.

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- The youth, foster parents and other significant adults are consulted regarding the youth's strengths and capabilities and needs.

- Independent living preparation includes skill and personal development in the areas which are critical for the youth's success in social, educational and vocational pursuits.

INTERVENTION STRATEGY #11:

ON-GOING SUPPORT IS PROVIDED FOR FAMILIES WHO COMMIT TO THE LONG-TERM CARE OF SPECIAL NEEDS DEPENDENT CHILDREN THROUGH GUARDIANSHIPS OR ADOPTIONS

Practice Outcomes:

- Families are offered financial assistance with counseling and medical coverage for children with preexisting special needs and conditions.

- Information and referral services are routinely available to support parents of these special needs children.

DESIRED CLIENT OUTCOMES

OUTCOME #1:

CHILDREN AND YOUTH ARE SAFER FROM SERIOUS INJURY OR DEATH RELATED TO CHILD ABUSE AND NEGLECT

Measures:

- Number of child abuse/neglect related child fatalities of children with open CPS/CWS/FRS cases at time of death or within 12 months of case closure.

- Number of identified injuries requiring medical treatment and child disclosures of recent sexual abuse on open CPS/CWS/FRS cases and cases closed within the past 12 months.

- Number of CPS re-referrals rated at high risk and/or with substantiated allegations after investigation, on open cases and cases closed within the past 12 months.

OUTCOME #2:

CHILDREN AND YOUTH ARE ABLE TO REMAIN SAFELY AT HOME

Measures:

- Number and type of services to reduce child abuse, neglect and family conflict, and to prevent placement, offered to families in open CPS/FRS/CWS cases.

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- Relevance of services, to identified problems and the family's culture, offered to reduce child abuse/neglect and to prevent placement in open CPS/FRS/CWS cases.

- Rate of placement of children and youth in active CPS/FRS caseloads.

- Rate of reunification of children and youth with their parent(s) in active CPS/FRS/CWS caseloads.

- Rate of subsequent out-of-home placement up to six months following family reunification in active and recently closed CPS/FRS/CWS caseloads.

- Rate of out-of-home placement of the child or youth originally at risk of placement up to six months following the provision of intensive family preservation services.

OUTCOME #3:

CHILDREN AND YOUTH IN OUT-OF-HOME CARE MAINTAIN POSITIVE CONNECTIONS WITH THEIR PARENTS, SIBLINGS AND EXTENDED FAMILY MEMBERS

Measures:

- Rate of out-of-home placements with relatives in open CPS/CWS/FRS/Adoption cases.

- Rate of visitation between children and youth in out-of-home care and their parents, siblings and extended family members in open CPS/FRS/CWS/Adoption placement cases.

- Number of telephone and written contacts between children and youth in out-of-home care and their parents, siblings and extended family members in open CPS/FRS/CWS/Adoption placement cases.

- Proximity of out-of-home placement to family's home in open CPS/FRS/CWS/Adoption placement cases.

- Proportion of adoption cases that are open adoptions.

- Report by parents and other family members that DCFS staff actively encouraged and facilitated contacts with their children and youth in out-of-home care.

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OUTCOME #4:

CHILDREN AND YOUTH LIVE IN A FAMILY WITH A COMMITMENT TO PERMANENT CARE-TAKING AS SOON AS POSSIBLE AFTER DCFS INVOLVEMENT

Measures:

- Length of time from the original date of placement with a family that has a commitment to permanent care-taking and where the child is expected to stay.

- Length of time from original date of placement to the accomplishment of permanency plans for children and youth in open CPS/FRS/CWS/Adoption cases for each type of permanent plan:

  - return home
  - legal guardianship
  - adoption
  - long-term foster care contract

OUTCOME #5:

OUT-OF-HOME CARE MEETS THE BASIC NEEDS OF CHILDREN AND YOUTH AND PROMOTES THE RESOLUTION OF SIGNIFICANT HEALTH, EDUCATIONAL AND EMOTIONAL ISSUES

Measures:

- Case records indicate that children and youth in out-of-home care receive required medical examinations.

- Case records indicate that children and youth in out-of-home care receive needed educational services.

- Case records indicate that children and youth in out-of-home care receive needed mental health services, including help in overcoming the trauma of child abuse and neglect, resolving loss and integrating the multiple families involved in their lives.

OUTCOME #6:

DCFS STAFF RELATE TO FAMILY MEMBERS IN AN OPEN, CLEAR AND RESPECTFUL MANNER

Measures:

- Family members report that they were treated respectfully by DCFS staff.

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- Family members report that DCFS staff agreed with them, at least in part, about their family's identified needs.

- Family members report that DCFS staff understood their family's problems.

- Family members report that DCFS staff explored their family's strengths, as well as their family's problems.

- Family members report that DCFS staff included them in service planning and that they were kept well informed about what was happening with their case.

- Family members report that the DCFS services they received were sensitive to their cultural background and to any special needs.

- Case records indicate that family members' strengths were identified and reinforced.

OUTCOMES #7:

PARENTS AND OTHER ADULT CARE-TAKERS ARE SUCCESSFULLY EMPOWERED AND ENGAGED IN SERVICES

Measure:

- The ratio of cases open past 90 days with voluntary service agreements to cases with court ordered service plans.

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FOSTER CARE BEHAVIOR MANGEMENT

ACKNOWLEDGEMENTS

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SUMMARY

In general, the guideline provides written expectations for foster parents on the use of strategies for the management of challenging child behaviors. The guideline was developed after a series of focus group meetings with providers and other stakeholders. We then brought together a writing committee. A number of changes have been made over the course of the review.

A summary of the major differences between current practice and the *Behavior Management Guide* follows:

- When the social worker and the foster parent agree the foster child presents challenging behaviors, the service plan should include a behavior management section.

- Restrictive strategies that would be permitted are a special timeout room, physical restraint, and mechanical restraint for safety purposes. Requirements are delineated for each.

- Each of the above three strategies require the following training:

    1. Training for working with challenging children *(current curriculum is Fosterparentscope)*;

    2. General behavior management training *(minimum 8 hours)*; and

    3. Specialized training in the specific technique to be used *(minimum 4 hours)*.

    - Documentation and notification of the social worker and licenser is required, if a foster parent uses a special timeout room, physical restraint, or mechanical restraints for safety reasons.

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I. FOUNDATION PRINCIPLES

The Children's Administration (CA) expects each child in state care to reside in an environment in which the child is valued, respected and well cared for. CA is responsible to ensure that high quality care is provided to all children living in state-regulated homes or facilities. CA policy, rules and contracts define high standards for the care of children and licensed providers are encouraged to obtain on-going training to help them meet these standards for excellence.

Children in care with the CA Division of Children and Family Services (DCFS), like all children, should be guided and instructed so that they may grow to become adults who demonstrate self-control, compassion, respect for others and an ability to care for themselves. CA endorses national best practice standards which encourage adults working with children to set clear expectations and limits, develop regular routines, encourage cooperation and problem solving, and use a full range of positive interventions before using more intrusive interventions such as physical restraint or a de-escalation room. Interventions with children which are designed to modify their behavior should be respectful, related to the issue at hand, flexibly applied and designed to help the child master age and developmentally appropriate skills.

Out-of-home care providers must comply with discipline and restraint requirements contained in the Washington Administrative Code (WAC) minimum licensing requirements (MLR) for the category of license or certification held by the provider. WAC minimum licensing requirements are available from your licenser or from the CA Division of Licensed Resources (DLR). The minimum licensing requirements can also be found on the DSHS home page.

Agencies holding contracts for specialized services are expected to meet or exceed the care standards outlined in their contracts.

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II. GENERAL EXPECTATIONS FOR CARE PROVIDERS

II. A. Positive Behavior Support

All out-of-home care providers licensed by the CA Division of Licensed Resources (DLR) must practice positive behavior support strategies for children in care. Positive behavior support is based on respect, dignity and offering choices *(as appropriate to the child's age and developmental level)*. Positive behavior support helps children develop effective strategies for getting their needs met and helps reduce behavior problems. Components of positive behavior support include:

1. ***Supportive environment:*** A supportive environment ensures children get their needs met when they use socially acceptable behaviors. It reduces a child's need to use problem behaviors to obtain an adult response. Adults in a supportive environment:

    a) Acknowledge the child's abilities and accomplishments;
    b) Notice what the child does right and encourage more of that behavior;
    c) Balance predictability and consistency with an ability to respond quickly to changes in the child's life and behavior; and
    d) Recognize stressful circumstances (such as poor sleep, hunger, illness, parental visits, or court dates) and make reasonable adjustments in expectations for the child.

2. ***Skill development:*** Adults increase behavioral control skills in children by:

    a) Explaining what is expected;
    b) Redirecting ineffective behavior;
    c) Offering choices;
    d) Modeling how to negotiate and problem solve;
    e) Supporting the child's efforts to effectively control her own behavior;
    f) Being aware of and managing their own responses to challenging behaviors;
    g) Providing a daily structure which supports the child's need for consistency;
    h) Developing a list of response options and matching the intensity of the adult response to the seriousness of the child's behavior;
    i) Giving consequences for unacceptable behavior;
    j) Encouraging each child to be appropriately involved in school and community activities; and
    k) Making sure each child has opportunities to form significant, positive friendships and family relationships.

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3. Health care: Prompt assessment and treatment of any ongoing or suspected medical condition allows adults to better understand what behaviors can reasonably be expected of a child. Adults ensure appropriate health care by:

a) Acting on concerns they have about a child's health;
b) Obtaining a yearly well-child exam *(sometimes called a Healthy Kids exam or an EPSDT screen)* and dental exam;
c) Keeping all scheduled medical and therapeutic appointments;
d) Educating themselves about the nature of the child's illness or condition and its expected effects on the child's behavior;
e) Following the instructions of the doctor or pharmacist;
f) Educating themselves about prescribed medications and possible side effects; and
g) Sharing medical and prescription information with other caregivers, including respite providers.

II. B. Care Provider Team Membership

1. Out-of-home care providers, such as foster parents and staff of licensed group homes, are part of the professional team working to complete the permanency plan for the child and his or her family. *(Other team members will vary by child but should include the social worker, a parent and relatives when possible, school district personnel, therapist and other concerned adults.)* Care providers are expected to contribute to development of the child's permanent plan and to engage in activities that support achieving the permanent plan.

2. When foster parents identify emotional or behavioral issues that require further assessment or require specialized planning to manage, they are expected to inform the social worker. The foster parent is to be included in development of a service plan to meet the identified needs. Foster parents are expected to implement their portions of any specialized service plan.

3. Foster parents are encouraged to keep and share a record of the child's stay in their home or facility which includes:

a) Any medical reports received;
b) Significant developmental milestones;
c) Interests, skills and abilities of the child;
d) Behaviors of concern and management strategies;
e) Schools attended, report cards and grades;
f) Names of all medical providers and dates of visits;
g) Immunizations;
h) Friends, pets; and

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i) Pictures of the child.

II. C. Care Provider Training Expectations

1. Children in the care of the state generally come from families where they have experienced abuse and/or neglect. They may demonstrate behaviors that reflect the abusive or neglectful treatment they have received. Foster parents are expected to obtain initial and on-going training to help them better understand the children in their care and to increase their ability to provide these children with a safe, stable and loving environment.

2. DLR offers training in every region designed to increase foster parent skills. Foster parents should take and complete training recommended or required by DLR.

3. Foster parents who wish to care for youth who receive exceptional cost payments (ECP), to support the child's needs, are required to complete specific training before they care for any child with an exceptional cost plan. More information is available from the child's social worker or regional foster parent trainer.

4. Respite providers must have the training needed to provide appropriate care for children under their supervision.

III. GENERAL EXPECTATIONS FOR SOCIAL WORKERS

The information in this section is adapted from the CA *Practices and Procedures Guide*, Chapter 4000 (Child Welfare Services), Section 4530 (Foster Care).

III. A. Social Worker Role in Placement

1. The social worker is responsible to ensure that when a child is placed in foster care the information needed to support that child is shared with the foster parent. In emergency placements of children not previously known to DCFS, the information may be scant. As more information is gathered, it must be shared with the care provider.

2. The social worker must provide the foster parent with as much relevant information as is known about the immediate condition of the child, the child's behaviors, school performance, health and medical condition, and those details of the permanency plan that will impact the child and the placement. Specific information to be provided includes:

a) Child's full name, birth date and legal status;

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b) Last school of attendance and eligibility for special education and related services;

c) Medical history including any medical problems, name of doctor, type of medical coverage and provider;
d) Mental health history and any current mental health and behavioral issues;
e) Name and address of parent or guardian;
f) Reason for placement;
g) Who to contact in an emergency;
h) Special instructions including supervision requirements and suggestions for managing problem behavior;
i) Name and telephone number of the social worker and of the social worker's immediate supervisor; and
j) Visitation plan.

3. When possible, the social worker must arrange for and be involved in pre-placement visits and in the actual placement of the child in the foster home or residential setting.

III. B. Social Worker Role in Planning and Teaming

1. As soon as possible after placement, the social worker makes a contact with the foster parent to see how the child is adjusting. The worker maintains, at a minimum, quarterly face-to-face contact with the child in the foster home.

2. The social worker uses a team approach in planning for each child. The social worker contacts the care provider and other concerned adults and considers their input before developing plans for a child.

3. When the social worker and the foster parent agree upon the child's challenging behaviors, the service plan which is developed must include a behavior management section which is individualized for the child and which addresses:

a) Things known to contribute to problem behaviors for the child;
b) Supervision needs;
c) Strategies for early intervention and de-escalation;
d) A list of ways to respond if de-escalation is not working; and
e) A plan for obtaining crisis consultation and support 24 hours a day.

4. The social worker documents the service plan including behavior management section in the child's Passport and/or in CAMIS as described elsewhere in agency policy.

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IV. BEHAVIOR MANAGEMENT STRATEGIES COVERED BY THIS GUIDELINE

Certain children will require behavioral interventions beyond those generally appropriate for the child's age and developmental level. These children are behaviorally reactive in ways that may pose a continuing serious threat to themselves, to others or to property. This guide provides information that will help with managing these behaviors with the goal of assisting the child to gain control of his or her own behavior.

IV. A. Situations Where This Guideline Does Not Apply

This guideline does not apply to age related, developmentally normal behaviors demonstrated by very young children that may require physical intervention. Some examples of appropriate adult interventions are listed below:

1. Intervening physically to ensure safety when a child demonstrates dangerous, impulsive behavior. An example of this is physically holding a three-year-old child who has suddenly tried to dart into the street.

2. Intervening physically to remove a child from a situation that is so stimulating the child is overwhelmed. An example of this is physically removing a tantruming two-year-old from a supermarket floor to the quiet of the car.

3. Appropriately using standard, industry approved infant and child safety restraints. Some examples include car seats, high chairs with safety belts, toddler harnesses and toddler safety gates.

4. Following steps outlined in an alternative behavior management plan for developmentally disabled children when a separate plan has been developed.

IV. B. Interventions Which Are Prohibited

The following interventions are prohibited in all licensed homes and facilities:

1. ***Corporal punishment of any kind.*** Examples of corporal punishment include but are not limited to: spanking with a hand or object, biting, jerking, kicking, shaking, pulling hair, or throwing the child;

2. ***Behavioral control methods that interfere with the child's right to humane care.*** Examples of methods which interfere with humane care include but are not limited to: deprivation of sleep, providing inadequate food, purposely inflicting pain as a punishment, name-calling or using derogatory comments, verbal abuse, or actions intended to humiliate;

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3. ***Depriving a child of the components of humane care***. Examples of the components of humane care include but are not limited to: necessary clothing, personal hygiene, adequate shelter, adequate food, and necessary medical or dental care;

4. ***Depriving the child of necessary services.*** Examples of necessary services include but are not limited to: contact with the assigned social worker, contact with the assigned legal representative, family contacts and/or therapeutic activities which are part of the child's DCFS Individual Service and Safety Plan (ISSP);

5. ***Use of medication in an amount or frequency other than that which has been prescribed by a physician or psychiatrist;***

6. ***Giving medications that have been prescribed for another person;***

7. ***Physically locking doors or windows in a way that would prohibit a child from exiting except as described in section VII. E*** *(De-escalation Room with Spring Lock on Door)* ***and section VIII.*** *(Secure Crisis Residential Centers).*

8. ***Physical restraint techniques which restrict breathing;***

9. ***Physical restraint techniques that inflict pain as a strategy for behavior control;***

10. ***Mechanical restraints used as a punishment.*** See section VII. F *(Use of Mechanical Restraints for Safety Reasons Related to Disability or Medical Condition)* for description of allowed use of mechanical restraints; and

11. ***Any activity that interferes with the child's basic right to humane care, protection, safety and security.***

IV. C. Licensed Facility Reporting Requirements

Any incident that meets the reporting requirements established by DLR for licensed facilities *(foster homes, group homes or other residential facility)* must be reported to CA Intake. The reporting requirements are published in the CA *Practices and Procedures Guide* and are available from your licenser.

V. LEAST RESTRICTIVE INTERVENTIONS

Foster parents must use the least restrictive procedure that adequately protects the child, other persons, or property. Potentially dangerous situations may often be defused if the

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care provider is alert, intervenes early to change the environment if appropriate, and uses active listening and de-escalation techniques.

Less restrictive interventions must be tried before more restrictive interventions are used unless there is serious threat of injury to the child or others or of serious property damage. Less restrictive interventions may be repeated many times to allow opportunities for learning to occur and the behavior to change.

V. A. Selecting A Behavior Management Strategy

Foster parents must be able to select a behavior management strategy or approach that is appropriate for the child, the behavior and the setting. In order to select an effective response that is appropriate to the level of risk posed by the behavior, foster parents must understand the following behavior management concepts:

1. Challenging behavior may be an indication of the child's need for greater positive adult support and attention.

2. A child may break rules in a premature effort to assume responsibility rather than in defiance of adult authority.

3. Adults may still provide effective guidance when they:

a) Allow the child to make mistakes as part of the learning process;
b) Occasionally ignore behavior; and
c) Allow the child to learn by experiencing the natural consequences of the behavior. Allowing natural consequences to occur is not an appropriate strategy if the consequence poses additional risk to the child. For example, it would not be appropriate to let a youth walk home at 10:00 PM because he spent his bus money.

4. Positive activities such as shooting hoops or journal writing can help children redirect excess energy or anger.

5. Challenging behaviors can often be redirected through the use of active listening and verbal de-escalation techniques.

6. Early intervention with risky behaviors may be necessary to prevent further acting out and reduce risk of harm to the child or others.

7. All behavior change strategies selected must be appropriate to the child's ability to understand; and

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8. Greater objectivity and effectiveness may be gained by consulting with other team members in selecting a strategy.

V. B. Giving Consequences as a Response to Inappropriate Behavior

This section applies to all licensed out-of-home care providers. Giving a child a consequence for inappropriate behavior is considered a "less restrictive" intervention. The types of consequences used should be discussed with the child during a calm time whenever possible. All care providers are encouraged to obtain training in general behavior management strategies. Developmentally disabled clients may require a different approach or strategy than those described below. Consult with the DDD caseworker as appropriate.

1. Foster parents may assign consequences for inappropriate behavior.

a) When consequences are used, they must be discussed with the child in such a way that they help the child gain self-control skills and encourage the child to make positive behavior choices.
b) The assigned consequence must not pose additional risk to the child. For example, a foster parent may not make a child spend the night outside because she came home after curfew.
c) Foster parents assigning a consequence must keep in mind the child's unique circumstances, history, age, developmental level, mental health issues, and cognitive abilities.
d) If the chosen consequence isn't working, adjust it quickly. Do not give up on the behavior plan. Find consequences that are effective.

2. Examples of consequences that are permitted include:

a) Allowing events to occur which are a natural or logical outcome of the behavior;
b) Giving a timeout *(briefly sending the child to a common area such as a bedroom or a special chair in the living room. Generally, one minute per year of age)*;
c) Meetings to discuss the behavior and strategies for change;
d) Extra chores appropriate for the child's age and abilities;
e) Loss of privileges such as television or telephone;
f) Early bed time/early curfew;
g) Time limited restriction from planned recreational activities;
h) Restricted access to areas generally available to the children in care;
i) Increased adult supervision;
j) Temporary removal of personal property used *(or threatened to be used)* by the child to inflict injury on self or others;
k) Restricting the child from possessing certain items; and

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l) Searches of personal property for restricted items.

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VI. PERMITTED RESTRICTIVE STRATEGIES

CA expects that foster parents will work cooperatively, as part of a team, with social workers and other concerned adults to develop appropriate plans for management of a child's behaviors. More information on this expectation is contained in Section II. General Expectations for Care Providers, and Section III. General Expectations for Social Workers.

VI. A. Restrictive Strategies Permitted in Foster Homes

1. Specialized training is **required** before a restrictive strategy may be used in a foster home setting. Each foster parent using a restrictive strategy must have completed DLR required training for working with challenging children *(current curriculum is FosterparentScope)* and a general behavior management training that addresses the theories and concepts outlined in section V. Least Restrictive Interventions. In addition, the foster care provider must have received specialized training in the technique being used (physical restraint, use of a mechanical restraint).

2. Restrictive behavior management strategies permitted in foster home settings after appropriate training has been completed include:

a) Use of a special unlocked timeout room in certain settings as described in section VII. A. Timeout Room;
b) Physical restraint as described in Section VII. B. Physical Restraint; and
c) Mechanical restraint only for safety purposes as described in Section VII. F. Use of Mechanical Restraints for Safety Reasons.

VI. B. Training Required Before Using Restrictive Strategies

Before foster parents may use a restrictive behavior management strategy, the foster parent must have received DLR required training for working with challenging children *(current curriculum is Fosterparentscope)*, general training in behavior management, and specific training in how to use the strategy being applied. Behavior management training must be documented and available for review and comment by DSHS staff.

1. ***General behavior management training*** must address the following topics at a minimum:

a) Recognizing events that could contribute to a crisis;
b) Assessing the physical environment;
c) Assessing personal response to challenging behaviors;
d) Verbal and non-verbal de-escalation strategies;
e) Selecting an intervention strategy that is appropriate to the situation;

f) Assessing when to end the use of the restrictive technique;
g) Debriefing the incident with the child and other adults; and
h) Incorporating knowledge gained into the service plan or treatment plan.

2. In order to adequately cover the topics listed above, general behavior management training should be no less than eight hours.

3. ***Specialized training*** must contain discussion of issues and instruction on procedures that are associated with the specific restrictive technique. For each restrictive technique, it is appropriate to receive a minimum of four to eight hours of specialized instruction.

4. Specialized instruction on a restrictive technique must address the following at a minimum:

a) Balancing child safety with temporary loss of freedom due to use of the restrictive technique;
b) How to appropriately apply the restrictive technique;
c) How to monitor and document use of the restrictive technique;
d) Assessing when to end use of the restrictive procedure;
e) Training and instruction strategies for the child which may reduce the need to use the restrictive technique; and
f) Incorporating information gained into the child's service plan or treatment plan.

VII. PROCEDURES FOR USE OF RESTRICTIVE INTERVENTIONS

VII.A. Special Timeout Room

A *special* timeout room which is located away from the activities of daily life may be used either as a consequence for poor behavior or to help a child gain behavioral control. ***This is a room separate from the child's bedroom or other living spaces.***

1. The purpose of timeout is to provide the child with some time to think and some distance from a difficult situation. Adults must explain to the child why a timeout was given and must help the child consider more appropriate ways to manage similar situations.

2. Generally, when a young child is given a timeout, it is appropriate for the child to spend one minute in timeout per each year in age. This expectation should be individually adjusted as needed to match the developmental age of the child.

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3. A *special* timeout room:

a) May not have a locking device of any type on the door;
b) Must meet the WAC requirement for a single bedroom including lighting, heating and adequate size;
c) Must be designed so that the child is visible while in the room;
d) Must have a comfortable atmosphere;
e) May be used only for brief amounts of time. Any period of time longer than 30 minutes requires written approval by the social worker for the child;
f) Must not allow any child to remain in isolation for more than four hours in a 24-hour period;
g) Requires a staff person to visually observe the child at least once in each 15-minute period;
h) Requires the child to be protected from any means of self-harm;
i) Requires documentation of the length of time and reason the child was placed in the timeout room; and
j) May be used for only one child at a time.

4. A *special* timeout room in a foster setting would be appropriate when children share a bedroom or the bedroom is not available as a timeout setting.

5. DLR must be notified that a *special* timeout room is planned, and DLR must have the opportunity to physically inspect the space for appropriateness.

VII.B. Physical Restraint

If physical restraint is necessary, it should be used primarily as part of a treatment and intervention plan for a child with identified behavior management difficulties. General behavior management training and specialized instruction on the use of physical restraint is required before use.

1. Physical restraint may be used only to prevent a child from:

a) Seriously injuring self or others;
b) Carrying out a believable threat to seriously injure self or others;
c) Seriously damaging property; or
d) Harm when needing to safely move a child to a less risky location.

2. Efforts to redirect or de-escalate the situation must be attempted before using a physical restraint unless the child's behavior poses an immediate risk to physical safety.

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3. Physical restraint may not be used as a form of punishment.

4. Physical restraint techniques which restrict breathing or which inflict pain as a strategy for behavior control are prohibited.

5. Physical restraint may be used only:

a) For a short time to provide the physical control that the child is unwilling or unable to provide for himself; and
b) For the purpose of promoting safety.

6. When the child verbally or non-verbally demonstrates an ability to control his behavior, the restraint is to be ended.

7. If escalated behavior persists, other options such as use of a special timeout room or de-escalation room should be considered, if available. Psychiatric hospitalization or police involvement should be considered if the child's presentation and behavior appear to meet the criteria for involvement by those resources.

8. Children being restrained must be continually monitored, ideally by someone not involved in the restraint, to ensure the child's health and safety.

9. Each use of physical restraint must be documented in writing. At a minimum, the documentation must record:

a) The child's name and age;
b) The date of the restraint;
c) The time in and time out of the restraint;
d) The events preceding the behavior which lead to use of the restraint;
e) The de-escalation strategies that were used;
f) Names of those involved in the restraint and any observers;
g) A description of the restraint;
h) A description of any injuries to the child, other children or caregivers;
i) An analysis of how the restraint might have been avoided; and
j) Signature of report author.

10. Foster parents must send documentation of the physical restraint to the child's social worker, licenser and keep a copy in their records.

VII.C. Emergency Use of Physical Restraint

Some children placed in foster care by CA will demonstrate unexpected behaviors that the

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provider is not specifically trained to manage.

1. If a child's behavior presents an immediate risk of serious harm to the child or others, or a serious threat to property, a physical restraint may be used ***in this emergency situation*** to ensure safety even if the foster parent has not received specialized training in this procedure.

2. The least restrictive procedure that will provide adequate protection must be used and it must be ended as soon as the need for protection is over.

3. Physical restraint techniques which inhibit breathing or which inflict pain for behavior control purposes are prohibited.

4. A report describing the restraint must be written by the foster parent and mailed or delivered to the social worker and licenser within 48 hours of each use of an emergency physical restraint. The report must identify the child and the foster parent, describe the events leading to use of the emergency restraint, the persons involved, the type of restraint used, whether there were any injuries, and how the incident was resolved.

5. When an emergency physical restraint has been used on a child, the foster parent and social worker must consult about

a) Immediate strategies for behavior management;
b) Whether the service plan adequately identifies and meets the needs of the child; and
c) Whether the child will remain in the current placement.

6. If the child remains in the current placement, the foster parent must obtain general and specialized behavior management training within three months. This training would include the appropriate use of restraints.

VII.D. Use of Mechanical Restraints for Safety Reasons Related To Disability or Medical Condition

A mechanical restraint is any object or device that is applied to the child to limit movement. Some developmentally disabled or medically fragile children may require mechanical devices to assist them with body positioning or to reduce opportunities for self-injury or wandering.

1. The following assistance devices are excluded:

a) Age appropriate, infant and toddler safety devices;

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b) Orthopedic braces;
c) Automobile and wheelchair safety belts.

2. Mechanical restraint for punishment purposes is prohibited in all licensed out-of-home care settings.

3. Mechanical restraint for safety purposes is permitted only when DLR has given the care provider a written waiver to the license that authorizes the provider to use a specific mechanical restraint for a specific child. These waivers are time limited and must be renewed.

4. Before using a mechanical restraint, the foster parent, social worker, and heath care provider must weigh the child's right to freedom of movement against the potential for injury to the child, if the restraint is not used.

5. When a mechanical restraint is being used with a child, the foster parent, social worker, physician (or designee), and other adults responsible for the child must regularly engage in discussions about whether the restraint is still needed and whether there are other less restrictive methods that could benefit the child. This consideration of other options must be documented by the social worker as part of the quarterly health and safety contact.

6. Before any mechanical restraint can be used, there must be a medical order signed by the child's physician, for this intervention. The medical order must:

a) Describe the specific restraint to be used and the circumstances in which it is to be used;
b) Identify the caregiver skills and knowledge needed to apply the restraint correctly; and
c) Suggest strategies for intervention that might reduce future need for use of the mechanical restraint.

7. An out-of-home care provider who has received a waiver to utilize a mechanical restraint must obtain training in the safe and appropriate use of the restraint in their setting. Any substitute or respite care providers must also be trained in safe and appropriate use of the restraint device.

8. A building evacuation plan must be written which clearly states who will be responsible for evacuating each restrained child in an emergency. When substitute care providers are on duty they must be informed of the building evacuation plan and which children they will be responsible for in the event of an emergency.

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GROUP CARE BEHAVIOR MANGEMENT

ACKNOWLEDGEMENTS

Thanks to the writing committee for their hard work on the guidelines. The committee included Karen Brady, Peggy Brown, Susan Corwin, Jean Croisant, Sophia Kouidou-Giles, Janice Langbehn, Sharon Newcomer, Michael Nash, Wilma Pincham, Nancy Sutton, Michael Vander Meer, and Wendy Warman.

SUMMARY

In general, the guideline provides written expectations for care providers on the use of strategies for the management of challenging child behaviors. The guideline was developed after a series of focus group meetings with providers and other stakeholders. We then brought together a writing committee. A number of changes have been made over the course of the review.

A summary of the major differences between current practice and the Behavior Management Guide for residential care settings follows:

- Restrictive strategies that would be permitted are a special time-out room, physical restraint, mechanical restraint for safety reasons related to disability or medical condition, de-escalation room, and de-escalation room with a spring or gravity lock. Requirements are delineated for each strategy in the guideline. There are specific requirements in regard to training, documentation and notification.

- De-escalation room with a spring or gravity lock door. This behavior management technique may only be used to assist in the control of youth that are large enough or aggressive enough that injury to the youth or staff is likely without its use.

  - This is a very restrictive strategy that requires a determination of "need" for such an option *(decision made jointly by the Division of Children and Family Services (DCFS) Regional Administrator, the Division of Licensed Resources (DLR) Regional Manager, and the Children's Administration (CA) Directors of Licensed Resources and Program and Policy Development)*;

  - There is a separate application to DLR for the use of this strategy;

  - Current certification of accreditation by COA or JCAHO or equivalent is required; and

  - A waiver granted by DLR with an appropriate plan for use of the locked room.

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I. FOUNDATION PRINCIPLES

The Children's Administration (CA) expects each child in state care to reside in an environment in which the child is valued, respected and well cared for. CA is responsible to ensure that high quality care is provided to all children living in state-regulated homes or facilities. CA policy, rules, and contracts define high standards for the care of children, and CA encourages licensed providers to obtain on-going training to help them meet these standards for excellence.

Children in care with the CA Division of Children and Family Services (DCFS), like all children, should be guided and instructed so that they may grow to become adults who demonstrate self-control, compassion, respect for others, and an ability to care for themselves. CA endorses national best practice standards which encourage adults working with children to set clear expectations and limits, develop regular routines, encourage cooperation and problem solving, and use a full range of positive interventions before using more intrusive interventions such as physical restraint or a de-escalation room. Interventions with children which are designed to modify the children's behavior should be respectful, related to the issue at hand, flexibly applied, and designed to help the children master age and developmentally appropriate skills.

Out-of-home care providers must comply with discipline and restraint requirements contained in the Washington Administrative Code (WAC) minimum licensing requirements (MLR) for the category of license or certification held by the provider. WAC minimum licensing requirements are available from your licenser or from the CA Division of Licensed Resources (DLR). The minimum licensing requirements may also be found on the DSHS home page.

Agencies holding contracts for specialized services are expected to meet or exceed the care standards outlined in their contracts with the department.

II. GENERAL EXPECTATIONS FOR CARE PROVIDERS

II. A. Positive Behavior Support

All out-of-home care providers licensed by Division of Licensed Resources (DLR) must practice positive behavior support strategies for children in care. Positive behavior support is based on respect, dignity and offering choices *(as appropriate to the child's age and developmental level)*. Positive behavior support helps children develop effective strategies for getting their needs met and helps reduce behavior problems. Components of positive behavior support include:

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1. ***Supportive Environment:*** A supportive environment ensures children get their needs met when they use socially acceptable behaviors. It reduces a child's need to use problem behaviors to obtain an adult response. Adults in a supportive environment:

   a) Acknowledge the child's abilities and accomplishments;
   b) Notice what the child does right and encourage more of that behavior;
   c) Balance predictability and consistency with an ability to respond quickly to changes in the child's life and behavior; and
   d) Recognize stressful circumstances *(such as poor sleep, hunger, illness, parental visits, or court dates)* and make reasonable adjustments in expectations for the child.

2. ***Skill Development:*** Adults increase behavioral control skills in children by:

   a) Explaining what is expected;
   b) Redirecting ineffective behavior;
   c) Offering choices;
   d) Modeling how to negotiate and problem solve;
   e) Supporting the child's efforts to effectively control her own behavior;
   f) Being aware of and managing their own responses to challenging behaviors;
   g) Providing a daily structure which supports the child's need for consistency;
   h) Developing a list of response options and matching the intensity of the adult response to the seriousness of the child's behavior;
   i) Giving consequences for unacceptable behavior;
   j) Encouraging each child to be appropriately involved in school and community activities; and
   k) Making sure each child has opportunities to form significant, positive friendships and family relationships.

3. ***Health Care:*** Prompt assessment and treatment of any ongoing or suspected medical condition allows adults to better understand what behaviors can reasonably be expected of a child. Adults ensure appropriate health care by:

   a) Acting on concerns they have about a child's health;
   b) Obtaining a yearly well-child exam *(sometimes called a Healthy Kids exam or an EPSDT screen)* and dental exam;
   c) Keeping all scheduled medical and therapeutic appointments;
   d) Educating themselves about the nature of the child's illness or condition and its expected effects on the child's behavior;
   e) Following the instructions of the doctor or pharmacist;
   f) Educating themselves about prescribed medications and possible side effects; and
   g) Sharing medical and prescription information with other caregivers, including respite providers.

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II. B. Care Provider Team Membership

1. Out-of-home care providers such as foster parents and staff of licensed group homes/residential facilities are part of the professional team working to complete the permanency plan for the child and his or her family. Other team members will vary by child but should include the social worker, a parent and relatives when possible, school district personnel, therapist and other concerned adults. Care providers are expected to contribute to development of the child's permanent plan and to engage in activities that support achieving the permanent plan.

2. When out-of-home care providers identify emotional or behavioral issues that require further assessment or require specialized planning to manage, they are expected to inform the social worker. The care provider is to be included in development of a service plan to meet the identified needs. The care providers are expected to implement their portions of any specialized service plan.

3. Out-of-home care providers are encouraged to keep and share a record of the child's stay in their home or facility which includes:

a) Any medical reports received;
b) Significant developmental milestones;
c) Interests, skills and abilities of the child;
d) Behaviors of concern and management strategies;
e) Schools attended, report cards and grades;
g) Names of all medical providers and dates of visits;
h) Immunizations;
i) Friends, pets; and
j) Pictures of the child.

II. C. Care Provider Training Expectations

1. Children in the care of the state generally come from families where they have experienced abuse and/or neglect. They may demonstrate behaviors that reflect the abusive or neglectful treatment they have received. Out-of home care providers are expected to obtain initial and on-going training to help them better understand the children in their care and to increase their ability to provide these children with a safe, stable and loving environment.

2. All child care staff in residential settings are expected to participate in the training opportunities available through their agencies that are designed to increase their skills in the care of challenging behaviors of the children cared for.

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3. Respite providers must have the training needed to provide appropriate care for children under their supervision.

III. GENERAL EXPECTATIONS FOR SOCIAL WORKERS

The information in this section is adapted from the Children's Administration Practices and Procedures Guide, Chapter 4000, Child Welfare Services, Section 4530, Foster Care.

III.A. Social Worker Role in Placement

1. The social worker is responsible to ensure that when a child is placed in foster care or residential care the information needed to support that child is shared with the care provider. In emergency placements of children not previously known to DCFS, the information may be scant. As more information is gathered, it must be shared with the care provider.

2. The social worker must provide the out-of-home care provider with as much relevant information as is known about the immediate condition of the child, the child's behaviors, school performance, health and medical condition, and those details of the permanency plan that will impact the child and the placement. Specific information to be provided includes:

a) Child's full name, birth date and legal status;
b) Last school of attendance and eligibility for special education and related services;
c) Medical history including any medical problems, name of doctor, type of medical coverage and provider;
d) Mental health history and any current mental health or behavioral issues;
e) Name and address of parent or guardian;
f) Reason for placement;
g) Who to contact in an emergency;
h) Special instructions including supervision requirements and suggestions for managing problem behavior;
i) Name and telephone number of the social worker and of the social worker's supervisor; and
j) The visitation plan.

3. When possible, the social worker must arrange for and be involved in pre-placement visits and in the actual placement of the child in the foster home or residential setting.

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III.B. Social Worker Role in Planning and Teaming

1. As soon as possible after placement, the social worker makes a contact with the care provider to see how the child is adjusting. The worker maintains, at a minimum, quarterly face-to-face contact with the child in the out-of-home care setting.

2. The social worker uses a team approach in planning for each child. The social worker contacts the care provider and other concerned adults and considers their input before developing plans for a child.

3. When the social worker and the care provider agree upon the child's challenging behaviors, the service plan which is developed must include a behavior management section which is individualized for the child and which addresses:

a) Things known to contribute to problem behaviors for the child;
b) Supervision needs;
c) Strategies for early intervention and de-escalation;
d) A list of ways to respond if de-escalation is not working; and
e) A plan for obtaining crisis consultation and support 24 hours a day.

4. The social worker documents the service plan including behavior management section in the child's Passport and/or in CAMIS as described elsewhere in agency policy.

IV. BEHAVIOR MANAGEMENT STRATEGIES COVERED BY THIS GUIDELINE

Certain children will require behavioral interventions beyond those generally appropriate for the child's age and developmental level. These children are behaviorally reactive in ways that may pose a continuing serious threat to themselves, to others or to property. This guideline provides information that will help with managing these behaviors with the goal of assisting the child to gain control of his or her own behavior.

IV.A. Situations Where This Guideline Does Not Apply

This guideline does not apply to age related, developmentally normal behaviors demonstrated by very young children that may require physical intervention. Some examples of appropriate adult interventions are listed below:

1. Intervening physically to ensure safety when a child demonstrates dangerous, impulsive behavior. An example of this is physically holding a three-year-old child who has suddenly tried to dart into the street.

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2. Intervening physically to remove a child from a situation that is so stimulating the child is overwhelmed. An example of this is physically removing a tantruming two-year-old from a supermarket floor to the quiet of the car.

3. Appropriately using standard, industry approved infant and child safety restraints. Some examples include car seats, high chairs with safety belts, toddler harnesses and toddler safety gates.

4. Following steps outlined in an alternative behavior management plan for developmentally disabled children when a separate plan has been developed.

IV.B. Interventions Which Are Prohibited

The following interventions are prohibited in ***all*** licensed homes and facilities:

1. Corporal punishment of any kind. Examples of corporal punishment include but are not limited to: spanking with a hand or object, biting, jerking, kicking, shaking, pulling hair or throwing the child;

2. Behavioral control methods that interfere with the child's right to humane care. Examples of methods which interfere with humane care include but are not limited to: deprivation of sleep, withholding personal hygiene privileges, providing inadequate food, purposely inflicting pain as a punishment, name-calling or using derogatory comments, verbal abuse, or actions intended to humiliate;

3. Depriving a child of the components of humane care. Examples of the components of humane care include but are not limited to: necessary clothing, adequate shelter, adequate food, and necessary medical or dental care;

4. Depriving the child of necessary services. Examples of necessary services include but are not limited to: contact with the assigned social worker, contact with the assigned legal representative, family contacts and/or therapeutic activities which are part of the child's DCFS Individual Service and Safety Plan (ISSP);

5. Use of medication in an amount or frequency other than that which has been prescribed by a physician or psychiatrist;

6. Giving medications which have been prescribed for another person;

7. Physically locking doors or windows in a way that would prohibit a child from exiting except as described in section VII. E, De-escalation Room with Spring Lock on Door, and section VIII, Secure Crisis Residential Centers.

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8. Physical restraint techniques that restrict breathing or intentionally inflict pain as a strategy for behavior control;

9. Mechanical restraints used as a punishment. See section VII. F, Use of Mechanical Restraints for Safety Reasons Related to Disability or Medical Condition, for description of allowed use of mechanical restraints; and

10. Any activity that interferes with the child's basic right to care, protection, safety and security.

IV.C. Licensed Facility Reporting Requirements

Any incident which meets the reporting requirements established by the Division of Licensed Resources (DLR) for licensed facilities *(foster homes, group homes or other residential facility)* must be reported to Children's Administration Intake. The reporting requirements are published in the Children's Administration Practices and Procedures Guide and are available from your licenser or the child's social worker.

V. LEAST RESTRICTIVE INTERVENTIONS

Out-of-home care providers must use the least restrictive procedure that adequately protects the child, other persons or property. Potentially dangerous situations may often be defused if the care provider is alert, intervenes early to change the environment if appropriate, and uses active listening and de-escalation techniques.

Less restrictive interventions must be tried before more restrictive interventions are used unless there is serious threat in injury to the child or others, or serious property damage. Less restrictive interventions may be repeated many times to allow opportunities for learning to occur and the behavior to change.

V.A. Selecting A Behavior Management Strategy

Care providers must be able to select a behavior management strategy or approach that is appropriate for the child, the behavior and the setting. In order to select an effective response that is appropriate to the level of risk posed by the behavior, care providers must understand the following behavior management concepts:

1. Challenging behavior may be an indication of the child's need for greater positive adult support and attention;

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2. A child may break rules in a premature effort to assume responsibility rather than in defiance of adult authority;

3. Adults may still provide effective guidance when they:

a) Allow the child to make mistakes as part of the learning process;
b) Occasionally ignore behavior; and
c) Allow the child to learn by experiencing the natural consequences of the behavior *(Allowing natural consequences to occur is not an appropriate strategy if the consequence poses additional risk to the child. For example, it would not be appropriate to let a youth walk home at 10:00 PM because the child spent his or her bus money.)*;

4. Positive activities such as shooting hoops or journal writing can help children redirect excess energy or anger;

5. Challenging behaviors can often be redirected through the use of active listening and verbal de-escalation techniques;

6. Early intervention with risky behaviors may be necessary to prevent further acting out and reduce risk of harm to the child or others;

7. All behavior change strategies selected must be appropriate to the child's ability to understand; and

8. Greater objectivity and effectiveness may be gained by consulting with other team members in selecting a strategy.

V.B. Giving Consequences as a Response to Inappropriate Behavior

This section applies to all licensed out-of-home care providers. Giving a child a consequence for inappropriate behavior is considered a "less restrictive" intervention. The types of consequences used by the care provider should be discussed with the child before use, whenever possible. All care providers are encouraged to obtain training in general behavior management strategies. Developmentally disabled clients may require a different approach or strategy than those described below. Consult with the DDD worker as appropriate.

1. Care providers may assign consequences for inappropriate behavior.

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2. When consequences are used, they must be discussed with the child in such a way that they help the child gain self-control skills and encourage the child to make positive behavior choices.

3. The assigned consequence must not pose additional risk to the child. *(For example, a provider may not make a child spend the night outside because the child came home after curfew.)*

4. Care providers assigning a consequence must keep in mind the child's unique circumstances, age, developmental level, and cognitive abilities; and

5. If the chosen consequence isn't working adjust it quickly. Do not give up on the behavior plan. Find consequences that are effective.

6. Examples of permitted consequences include:

a) Allowing events to occur which are a natural *(or logical)* outcome of the behavior as long as the child is not unsafe;
b) Time-out *(briefly sending the child to a common area such as a bedroom or a special chair in the living room; generally, one minute for each year of age.)*;
c) Meetings to discuss the behavior and strategies for change;
d) Extra chores appropriate for the child's age and abilities;
e) Loss of privileges such as television or telephone;
f) Early bed time/early curfew;
g) Time limited restriction from planned recreational activities;
h) Restricted access to areas generally available to the children in care;
i) Increased adult supervision;
j) Temporary removal of personal property used *(or threatened to be used)* by the child to inflict injury on self or others;
k) Restricting the child from possessing certain items; and
l) Searches of personal property for restricted items.

VI. PERMITTED RESTRICTIVE STRATEGIES

It is expected that care providers will work cooperatively, as part of a team, with social workers and other concerned adults to develop appropriate plans for management of a child's behaviors. More information on this expectation is contained in Section II, General Expectations for Care Providers, and Section III, General Expectations for Social Workers.

VI.A. Restrictive Strategies Permitted in Residential Facilities

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1. Specialized training is ***required*** before a restrictive strategy may be used in a group home or other residential facility. Each child care staff using a restrictive strategy must have completed orientation to the agency's discipline policy and procedures and a general behavior management training which addresses the concepts described in Section V. Least Restrictive Interventions. In addition, the child care staff must have received specialized training in the technique being used.

2. Restrictive behavior management strategies permitted in group homes and other residential facilities include:

a) Use of an unlocked special time-out room as described in Section VII.A, Special Timeout Room;
b) Use of an unlocked de-escalation room as described in section VII.D, De-escalation Room in Residential Setting;
c) Physical restraint as described in Section VII.B, Physical Restraint; and
d) Mechanical restraint only for safety purposes as described in Section VII.F, Use of Mechanical Restraint for Safety Reasons Related to Disability or Medical Condition.
e) De-escalation room with spring or gravity lock on the door as described in Section VII.E, De-escalation Room with Spring or Gravity Lock.

3. A de-escalation room with a spring or gravity lock on the door may be used in limited residential care facilities which have obtained a license waiver from DLR and which have an on-going training program in appropriate use of this specialized device. DLR may withdraw permission to use the spring locks if DLR has evidence the device is being used inappropriately.

a) A spring or gravity locking device requires continuous personal pressure from a staff person to engage the device. Without personal pressure, the device rests in the open, unlocked position.
b) Application process and conditions for use of a spring or gravity locking device are further described in section VII.E, De-escalation Room with Spring Lock on Door.

VI.B. Training Required Before Using Restrictive Strategies

Before a care provider can use a restrictive behavior management strategy, the provider must have received general training in behavior management and specific training in how to use the strategy being applied. Behavior management training must be documented and available for review and comment by DSHS staff.

1. ***General*** behavior management training must address the following topics at a minimum:

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a) Recognizing events that could contribute to a crisis;
b) Assessing the physical environment;
c) Assessing personal response to challenging behaviors;
d) Verbal and non-verbal de-escalation strategies;
e) Selecting an intervention strategy appropriate to the situation;
f) Debriefing the incident with the child and other adults; and
g) Incorporating knowledge gained into the service plan or treatment plan.

2. In order to adequately cover the topics listed above, general behavior management training should be no less than eight hours.

3. ***Specialized*** training must contain discussion of issues and instruction on procedures that are associated with the specific restrictive technique. For each restrictive technique, it is appropriate to receive a minimum of four to eight hours of specialized instruction.

4. Specialized instruction on a restrictive technique must address the following at a minimum:

a) Balancing child safety with temporary loss of freedom due to use of the restrictive technique;
b) How to appropriately apply the restrictive technique;
c) How to monitor and document use of the restrictive technique;
d) Assessing when to end use of the restrictive procedure;
e) Training and instruction strategies for the child which may reduce the need to use the restrictive technique; and
f) Incorporating information gained into the child's service plan or treatment plan.

VII. PROCEDURES FOR USE OF RESTRICTIVE INTERVENTIONS

VII.A. Special Timeout Room

A *special* timeout room which is located away from the activities of daily life may be used either as a consequence for poor behavior or to help a child gain behavioral control. ***This is a room separate from the child's bedroom or other living space.***

1. The purpose of time out is to provide the child with some time to think and some distance from a difficult situation. Adults must explain to the child why a time out was given and must help the child consider more appropriate ways to manage similar situations.

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2. Generally, when a young child is given a time out, it is appropriate for the child to spend one minute in time out per each year in age. This expectation should be individually adjusted as needed to match the developmental age and safety needs for youth in residential care. The guidelines in #3 below are requirements for all residential settings.

3. A *special* time-out room:

a) May not have a locking device of any type on the door;
b) Must meet the MLR for a single bedroom including lighting, heating, ventilation and adequate size;
c) Must be designed so the child is visible while in the room;
d) Must have a comfortable atmosphere;
e) May be used only for brief amounts of time. Any period of time longer than 30 minutes requires written approval by the program director;
f) Must not allow any child to remain in isolation for more than four hours in a 24-hour period;
g) Requires a staff person to visually observe the child at least once in every 15-minutes;
h) Requires a child be protected from any means of self-harm;
i) Requires documentation of the length of time and reason the child was placed in the timeout room; and
j) May be used for only one child at a time.

4. DLR must be notified that a special time-out room is planned and they must have the opportunity to physically inspect the space for appropriateness. DLR will also need to review the program/ facilities record keeping and documentation procedures and logs for the use of the special timeout room.

VII.B. Physical Restraint

If physical restraint is necessary, it should be used primarily as part of a treatment and intervention plan for a child with identified behavior management difficulties.

1. Physical restraint may be used only to prevent a child from:

a) Seriously injuring self or others;
b) Carrying out a believable threat to seriously injure self or others;
c) Seriously damaging property; or
d) Harm when needing to move them to a less risky location.

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2. Efforts to redirect or de-escalate the situation must be attempted before using a physical restraint unless the child's behavior poses an immediate risk to physical safety.

3. Physical restraint may not be used as a form of punishment.

4. Physical restraint techniques which restrict breathing or which intentionally inflict pain as a strategy for behavior control are prohibited.

5. Physical restraint may be used only for a short time to provide the physical control that the child is unwilling or unable to provide for himself or herself. When the child verbally or non-verbally demonstrates an ability to control his or her behavior, the restraint is to be ended.

6. If escalated behavior persists, other options such as use of a timeout room or de-escalation room should be considered. Psychiatric hospitalization or police involvement should be considered if the child's presentation and behavior appear to meet the criteria for involvement by those resources.

7. Children being restrained must be continually monitored, ideally by someone not involved in the restraint, to ensure the child's health and safety.

8. Residential care staff should follow their internal agency documentation policies.

9. Each use of physical restraint must be documented in writing. At a minimum, the documentation must record:

a) The child's name and age;
b) The date of the restraint;
c) The time in and time out of the restraint;
d) The events preceding the behavior which lead to use of the restraint;
e) The de-escalation strategies that were used;
f) Names of those involved in the restraint and any observers;
g) A description of the restraint;
h) A description of any injuries to the child, other children or caregivers;
i) An analysis of how the restraint might have been avoided; and
j) Signature of report author.

VII.C. Emergency Use of Physical Restraint

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Some children placed in out-of-home care by Children's Administration will demonstrate behaviors which were not expected and which the provider is not specifically trained to manage.

1. If a child's behavior presents an immediate risk of serious harm to the child or others or presents a serious threat to property, a physical restraint may be used ***in these emergency situations*** to ensure safety even if the care provider has not received specialized training in this procedure.

2. The least restrictive procedure that will provide adequate protection must be used and it must be ended as soon as the need for protection is over.

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3. Physical restraint techniques that inhibit breathing or intentionally inflict pain for behavior control purposes are prohibited.

4. A report describing the restraint must be written by the care provider and mailed or delivered to the DCFS social worker and DLR facility licenser within 48 hours of each use of an emergency physical restraint. The report must identify the child and the provider and describe the events leading to use of the emergency restraint, the persons involved, the type of restraint used, whether there were any injuries and how the incident was resolved.

5. When an emergency physical restraint has been used on a child, the care provider/program director and social worker must consult about:

a) Immediate strategies for behavior management;
b) Whether the service plan adequately identifies and meets the needs of the child; and
c) Whether the child will remain in the current placement.

6. If the child remains in the current placement, the care provider must obtain general and specialized behavior management training within three months. This training would include the appropriate use of restraints.

VII.D. De-escalation Room in Residential Treatment Facilities

Some children may demonstrate an inability to regain control of their behavior in a setting that contains stimulation. These children may require the use of a de-escalation room to assist them in regaining behavioral control.

1. This restrictive intervention is available only in licensed group homes that have policies and procedures in place which ensure:

a) Each child in care has a behavior management plan;
b) Residential care staff are trained in appropriate use of a de-escalation room;
c) Clinical treatment staff are involved in decisions about use of the de-escalation room; and
d) Clinical and management staff regularly analyze whether this strategy is being used appropriately.

2. A de-escalation room may be used only when necessary to prevent a child from:

a) Inflicting immediate, serious injury to self or others;
b) Carrying out a believable threat to inflict serious injury to self or others;
c) Seriously damaging property; or

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d) Continuing to escalate because of environmental stimuli.

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3. A de-escalation room:

a) Must be barrier free and suicide resistant;
b) Must meet the MLR for size of a single bedroom *(80 square feet.)*;
c) Must have ventilation, heating and lighting. A dimmer switch is permitted to soften *(but not eliminate)* the amount of light;
d) Must be designed so the child is visible while in the room;
e) May not have a mechanical locking device which remains locked when unattended.
f) Must be used with only one child at a time;
g) May be used only for brief amounts of time. Any period of time longer than 30 minutes requires written approval by the program director;
h) Requires approval of physician for any amount of time over two hours; and
i) Does not allow a person to remain in isolation for more than four hours in a 24-hour period.

4. ***Appropriate use:*** A de-escalation room may not be used as a form of punishment. It may be used temporarily to provide only that degree of physical isolation that is needed to allow the child to regain control of her behavior. When the child verbally or non-verbally demonstrates an ability to manage her behavior, de-escalation room use is to be ended.

5. When the de-escalation room is occupied, a staff person must be close by, within hearing distance, at all times. A staff person must visually observe the child on a non-predictable schedule. The frequency of visual checks should relate directly to the risk behaviors demonstrated by the child. There must be no more than 15 minutes between visual observations. This observation schedule must be documented.

6. Efforts to counsel and calm the child must be conducted periodically and in all instances before 60 minutes has passed. These interventions must be documented.

7. De-escalation room use may be ended at any time the child demonstrates he or she is ready. An evaluation of whether this intervention is still needed must be conducted within 60 minutes after a child is placed in a de-escalation room.

8. If the child continues to demonstrate behavior which is a serious threat to self, others or property, staff must use agency policies and procedures to obtain clinical and management guidance on appropriate next steps.

9. Each de-escalation room use must be documented in writing. At a minimum, the documentation must record:

a) The child's name and age;

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b) The date of the de-escalation room use;
c) The time in and time out of de-escalation room;
d) Names of adults and other children involved in the incident;
e) The events preceding the behavior that lead to use of the de-escalation room;
f) The de-escalation strategies that were used;
g) A description of the incident;
h) A description of any injuries to the child, other children, or staff;
i) Visual observations made while the child is in the de-escalation room;
j) The outcome of the de-escalation room use;
k) Any revisions recommended to the child's behavior management plan;
l) Signature of report author; and
m) Supervisory and management signatures per agency policy.

VII.E. De-escalation Room with Spring or Gravity Lock on Door

A spring or gravity lock requires continuous personal pressure from a staff person to engage the lock. Without personal pressure, the device rests in the open, unlocked position.

1. Spring locks are an additional restrictive measure that may be used only in limited residential care facilities that have obtained a written license waiver from DLR.

2. All the procedures for use of a de-escalation room described in VI.C, De-escalation Room in Residential Treatment Facilities, apply to use of these locks.

3. The spring lock on a de-escalation room door may be engaged only to assist in the behavioral control of youth that are large enough or aggressive enough that injury to the youth or staff is likely without use of the spring lock.

4. Staff must document each time the spring lock is engaged and released during the course of an incident.

5. Residential facilities that would like to develop this option for behavior management must hold a current group home license or equivalent. The facilities must be currently accredited by a national organization such as the Council on Accreditation of Services for Families and Children (COA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

6. Prior to use of a spring lock, the residential facility must apply to the regional office of the Division of Licensed Resources. The application must include:

a) A letter of intent;
b) A copy of their certificate of accreditation;

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c) Copies of their policies and procedures relevant to behavior management and use of the de-escalation room with and without the locking device;
d) Copies of their staff training plan, incident documentation procedures and incident debriefing procedures; and
e) Quality assurance plans related to review of the use of all restrictive interventions including a spring-lock.

7. A review team will be designated to evaluate the application for both the need for a facility with capacity for this restrictive intervention and the appropriateness of the plans submitted. The team will consist of regional staff from DLR and DCFS, as well as state office staff from DLR and the Division of Program and Policy Development.

8. The review team will deliver their recommendations to the DCFS Regional Administrator, the DLR Regional Manager, the CA Director of Licensed Resources, and the CA Director of Program and Policy Development. The joint management team will determine whether to approve the application. If the application is approved, DLR will issue a waiver to the license. If the application is denied, a letter explaining the decision will be issued by DLR.

9. Any waiver to the license must be renewed as established by DLR policy.

VII.F. Use of Mechanical Restraints for Safety Reasons Related To Disability or Medical Condition

A mechanical restraint is any object or device that is applied to the child to limit movement. Some developmentally disabled or medically fragile children may require mechanical devices to assist them with body positioning or to reduce opportunities for self-injury or wandering.

1. The following assistance devices are excluded:

a) Age appropriate, infant and toddler safety devices;
b) Orthopedic braces;
c) Automobile and wheelchair safety belts.

2. Mechanical restraint for punishment purposes is prohibited in all licensed out-of-home care settings.

3. Mechanical restraint for safety purposes is permitted only when DLR has given the care provider a written waiver to the license that authorizes the provider to use a specific mechanical restraint for a specific child. These waivers are time limited and must be renewed.

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4. Before using a mechanical restraint, the out-of-home care provider, social worker and heath care provider must weigh the child's right to freedom of movement against the potential for injury to the child if the restraint is not used.

5. When a mechanical restraint is being used with a child, the out-of-home care provider, social worker, physician *(or designee)* and other adults responsible for the child must regularly engage in discussions about whether the restraint is still needed. Also to be considered is whether there are other less restrictive methods that could benefit the child. This consideration of other options must be documented by the social worker as part of the quarterly health and safety contact.

6. Prior to the use of any mechanical restraint, there must be a medical order, signed by the child's physician, for this intervention. The medical order must:

a) Describe the specific restraint to be used and the circumstances in which it is to be used;
b) Identify the caregiver skills and knowledge needed to apply the restraint correctly; and
c) Suggest strategies for intervention that might reduce future need for use of the mechanical restraint.

7. An out-of-home care provider who has received a waiver to utilize a mechanical restraint must obtain training in the safe and appropriate use of the restraint in their setting. Any substitute or respite care providers must also be trained in safe and appropriate use of the restraint device.

8. A building evacuation plan must be written that clearly states who will be responsible for evacuating each restrained child in an emergency. When substitute care providers are on duty they must be informed of the building evacuation plan and which children they will be responsible for in the event of an emergency.

VIII. SECURE CRISIS RESIDENTIAL CENTERS

Only Secure Crisis Residential Centers are authorized to have exterior door and window locks that restrict exit from the building, and to have secure perimeter fencing. Locked confinement within a Secure Crisis Residential Center or other licensed out-of-home care facility is not permitted.

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DIVISION OF DEVELOPMENTAL DISABILITIES
Olympia, Washington

TITLE: POSITIVE BEHAVIOR SUPPORT POLICY 5.14

Authority:	Chapter 71A RCW	Developmental Disabilities
	Chapter 388-820 WAC	Community Residential Services and Supports
	Chapter 388-825 WAC	DD Services Rules
	Chapter 388-850 WAC	County Employment and Day Programs

BACKGROUND:

The mission of the Division of Developmental Disabilities (DDD) is to endeavor to make a positive difference in the lives of people eligible for services, through offering quality supports and services that are: individual/family driven; stable and flexible; satisfying to the person and their family; and able to meet individual needs. Supports and services shall be offered in ways that ensure people have the necessary information to make decisions about their options and provide optimum opportunities for success.

DDD wants people to experience positive life benefits as described in the *DDD Residential Service Guidelines*. These benefits include:

- Health and safety;
- Personal power and choice;
- Personal value and positive recognition by self and others;
- A range of experiences which help them participate in the physical and social life of their communities;
- Good relationships with friends and relatives; and
- Competence to manage daily activities and pursue personal goals.

PURPOSE:

This policy describes the division's general approach to promoting quality of life and adaptive behavior through the *DDD Residential Service Guidelines* and by providing positive behavior support for individuals with challenging or problem behaviors.

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SCOPE:

This policy applies to all persons who receive services in:

1. DDD certified and contracted residential programs serving people in their own homes;
2. State Operated Living Alternatives (SOLA);
3. Intermediate Care Facilities for the Mentally Retarded (ICF/MR);
4. Residential Habilitation Centers (RHC); and
5. Services provided by counties that are funded by DDD.

POLICY:

A. Positive Behavior Support

Positive behavior support is an approach for dealing with problem behavior that focuses on changing the environment and skill deficits that contribute to the person's problem behavior. Positive behavior support must be emphasized in all services funded by DDD for persons with developmental disabilities.

Positive behavior support is based on respect, dignity, and personal choice. It helps develop effective means of meeting a person's needs and helps reduce problem behaviors. Different people will require different positive supports. Common types of support are:

- Assisting a person to live in a home which is safe, attractive, and in a location which is readily accessible to the community, activities, friends, and relatives; and
- Providing a person opportunities and assistance to:
  - Learn how to make choices and exercise personal power;
  - Manage daily activities, pursue personal goals, and access good health care;
  - Form and maintain significant friendships and relationships; and
  - Participate in a broad range of activities that the person enjoys and which promote positive recognition by self and others. This includes work, leisure, socialization and personal interests.

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B. Components of Positive Behavior Support

- Supportive Environments and Learning Opportunities

A supportive environment helps a person meet his or her needs through positive expression instead of needing to resort to problem behaviors to get the environment to respond. In a supportive environment, caregivers proactively plan to meet a person's needs. Many things contribute to a good environment, including:

- Promoting warm and caring relationships, especially with caregivers;
- Increasing a person's opportunity to make daily choices;
- Reducing factors and forms of treatment that may make a person feel anxious, afraid, angry or devalued;
- Arranging environmental factors, such as location of residence, access to transportation, and user-friendly kitchens;
- Providing consistent, positive responses to appropriate behavior on the part of the person;
- Providing a consistent, predictable environment;
- Calmly interrupting and redirecting inappropriate behavior; and
- Assisting the person to understand, to the best of their ability, how and why behavior change is helpful.

- Skill Development and Status

Skill development and improvement help increase a person's status and confidence. Skill development is dependent upon age, capabilities, interests, and personal motivation. Important types of support are:

- Teaching a person new skills to obtain what they want;
- Improving a person's communication skills;
- Increasing participation in typical community activities *(work, socialization, shopping, recreation, and leisure, etc.)*;
- Fostering skills and behaviors that promote mental and physical wellness;
- Encouraging a person to take more responsibility in their lives; and
- Helping a person to find ways to make contributions to others.

- Health Care

Health care support needs to be offered to the person to ensure prompt assessment and treatment of any ongoing or suspected problem. Untreated or under-treated health problems are often related to challenging behavior. Health care support should be offered until the problem is resolved. Establishing an ongoing relationship with a primary health

care provider is part of health care support.

- Treatment of Mental Illness

Persons who have a mental illness or mental health issues should be evaluated by a mental health professional, preferably one with expertise in developmental disabilities. The professional's recommendations should be considered in developing the person's positive behavior support plan. This may include prescription of psychoactive medication. Any use of psychoactive medication should be integrated into the larger plan to build a supportive environment for the person.

For persons receiving certified contracted residential services and services through SOLA, refer to DDD Policy 5.16, *Use of Psychoactive Medications*.

For persons residing in Community ICF/MRs and Residential Habilitation Centers (RHCs), refer to DDD Policy 9.02, *Administration of Psychotropic/Neuroleptic Drugs and Other Medications for Behavior Management or Treatment of Mental Illness*.

- Protection From Harm

Some people's behaviors may pose the threat of harm or injury to themselves, others, or property. In order to prevent injury or the destruction of property, physical intervention or restraint may be necessary. When this is the case, physical intervention is used only for the protection of the person, others, or property. Refer to DDD Policy 5.15, *Use of Restrictive Procedures*, and Policy 5.17, *Physical Intervention Techniques*, for more information.

- Functional Assessment

Some individuals have challenging behaviors that may interfere with their ability to have positive life experiences and form and maintain relationships. Positive behavior support uses functional assessment to help build respectful support plans for persons with challenging or problem behaviors.

A functional assessment is a process that evaluates:

- The overall quality of a person's life;
- The factors or events which increase the likelihood of problem behavior;
- The factors or events which increase the likelihood of appropriate behavior;
- When and where the problem behavior occurs most frequently;
- The presence of a diagnosed mental illness or neurological dysfunction which may contribute to the problem behavior; and

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- The functions of the problem behavior *(what the person obtains or avoids by engaging in the behavior)*.

C. Positive Behavior Support Plans

The completed functional assessment provides the basis for developing individualized positive behavior support plans, which will help reduce the frequency and severity of the challenging or problem behavior. These supports form the core of a Positive Behavior Support Plan (BSP).

BSPs are required when challenging or problem behaviors interfere with a person's ability to have positive life experiences and form and maintain relationships.

A BSP generally contains the following common elements:

- Recommendations for improving the general quality of a person's life as described throughout this policy;
- Providing increased interesting activities to fill a person's time;
- Reducing events that are likely to provoke the problem behavior;
- Methods to teach alternative appropriate behaviors that will achieve the same results as the problem behavior;
- Methods to reduce the effectiveness of the problem behavior in obtaining the desired outcomes; and
- Professional recommendations for treating mental illness and/or neurological dysfunction.

For people with challenging or problem behavior, BSPs emphasize positive supports that are essential to the person successfully meeting their needs.

SUPERSESSION:

DDD Policy 5.14
Issued April 13, 2000

DDD Policy 5.14
Issued May 26, 1999

DDD Policy 5.14
Issued January 30, 1996

DDD Policy 5.12
Issued December 28, 1993

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Approved: /s/ *Linda Rolfe* Date: July 1, 2001
Director, Division of Developmental Disabilities

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TITLE: USE OF RESTRICTIVE PROCEDURES POLICY 5.15

Authority:	Chapter 71A RCW	Developmental Disabilities
	Chapter 388-820 WAC	Community Residential Services and Supports
	Chapter 388-825 WAC	DD Services Rules
	Chapter 388-850 WAC	County Employment and Day Programs

BACKGROUND:

When a person's behavior presents a threat of injury to self or others, or threatens significant damage to the property of others, steps must be taken to protect the person, others, or property from harm. It is expected that supports as described in the Division of Developmental Disabilities (DDD) Policy 5.14, *Positive Behavior Support*, will be used to lessen the behaviors and to eliminate the need for restrictive practices. When positive behavior support alone is insufficient, procedures that involve temporary restrictions to the person may be necessary.

PURPOSE:

This policy describes which restrictive procedures are allowed and which are prohibited, the circumstances under which allowed restrictive procedures may be used, the requirements that must be met before they may be used, and the requirements for documenting and monitoring their use. For clarification, procedures that are not restrictive and do not require behavior support plans (BSP) are also described.

SCOPE:

This policy applies to all persons who receive services in:

1. DDD certified and contracted residential programs serving people in their own homes;
2. State Operated Living Alternatives (SOLA);
3. Intermediate Care Facilities for the Mentally Retarded (ICF/MR);
4. Residential Habilitation Centers (RHC); and
5. Services provided by counties that are funded by DDD.

State laws (RCWs) and rules (WACs) governing adult family homes, boarding homes and nursing homes take precedence over this policy.

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DEFINITIONS:

Aversive stimulation means the application of a stimulus that is unpleasant to the person *(e.g., water mist to the face, unpleasant tastes applied directly to the mouth, noxious smells, etc.).*

Corporal punishment means physical punishment of any kind.

Electric shock means the application of an electric current or charge to any part of the body *(electroconvulsive therapy (ECT) for depression is not included in this definition).*

Forced compliance means physically forcing or ordering a person to do something they do not want to do.

Locking a person alone in a room means egress is not possible.

Mechanical restraint means applying a device or object, which the person cannot remove, to the person's body for the purpose of restricting their free movement.

Overcorrection means requiring a person to clean or fix the environment more than necessary to restore it to its original state, and/or to repeatedly practice the correct way to do something as a consequence for having done something wrong.

Physical restraint means physically holding or restraining all or part of a person's body in a way that restricts their free movement.

Physical or mechanical restraint in a prone position means the person is being restrained while lying on their stomach.

Restrictive procedure means a procedure that restricts a person's freedom of movement, restricts access to personal property, requires a person to do something which she or he does not want to do, or removes something the person owns or has earned.

POLICY:

A. Restrictive procedures must be used only as provided for in this policy.

B. In addition to this policy, **Intermediate Care Facilities for the Mentally Retarded (ICF/MR)** must conform to all federal and state rules, regulations, policies and procedures governing restrictive practices. Facilities licensed as **boarding homes** must conform to all applicable rules as stated in Chapters 388-78A WAC, which also address the use of

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restraints. **Adult Family Homes** must adhere to Chapter 388-76 WAC regarding resident rights and restraints.

C. Restrictive procedures may only be used for the purpose of protection, and may not be used for the purpose of changing behavior in situations where no need for protection is present.

D. Only the least restrictive procedures needed to adequately protect the person, others, or property shall be used, and restrictive procedures must be terminated as soon as the need for protection is over.

E. **Prohibited Procedures**

1. Procedures that are not permitted under any circumstances and for which no exceptions to policy (ETP) are granted are:

   a. Corporal/physical punishment;
   b. Electric shock;
   c. Forced compliance, including exercise, when it's not for protection;
   d. Locking a person alone in a room;
   e. Overcorrection;
   f. Physical or mechanical restraint in a prone position *(i.e., lying on the stomach)*;
   g. Removing or taking away money, tokens, points or activities that a person has previously earned;
   h. Requiring a person to re-earn money or items purchased previously; and
   i. Withholding or modifying food as a consequence for behavior *(e.g., withholding dessert because the person was aggressive)*.

2. Aversive stimulation is not permitted except for treatment of sexual deviancy where a certified sex offender therapist conducts the treatment and informed consent and an ETP have been obtained. See Section J of this policy for additional information.

F. **Restrictive Procedures Permitted Only By Exception to Policy (ETP)**

The procedures listed below are considered severely intrusive and may be used only when less intrusive procedures have failed to protect the person, others, or property. Use of these procedures requires a behavior support plan (BSP) and an ETP.

Where noted below, an ETP is not required for Community Protection Program (CPP) participants <u>if</u> the restriction is included in the person's professional treatment plan. Refer to DDD Policies 15.01 through 15.05 on the *Community Protection Program* for further information.

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1. Restraint chairs specifically modified for mechanically restraining a person. Any use of a restraint chair requires the prior written approval of the division director.

2. Restraint boards. Any use of a restraint board requires the prior written approval of the division director.

3. Time out rooms *(placing a person alone in a room in which no reinforcement is available and from which the person is prevented from leaving).* Time out rooms must meet federal ICF/MR regulations and guidelines.

4. Restricting access to certain populations, areas, or public places. **Note:** an ETP is not required for CPP participants.

5. Restrictions on free association and communication, such as access to pornography, telephones, the Internet, written communication, communication devices, and interactions with others *(e.g., limiting 900 calls/telephone service, supervising telephone usage to monitor behavior).* **Note:** an ETP is not required for CPP participants

6. Restricting access to alcohol. **Note:** an ETP is not required for CPP participants.

7. Requiring an individual to wear any electronic monitoring device on their person to monitor their behavior. The person and their guardian must give consent if there is no court order.

8. Routine search *(i.e., a planned or scheduled search)* of a person and/or their home and possessions. Without a court order or as a condition of community supervision, the person and their guardian must consent to the procedure. A legitimate and significant reason to conduct the search must exist. **Note:** an ETP is not required for CPP participants.

9. Removal of personal property where risk of damage to property or injury to a person is not an issue *(e.g., taking the person's TV away for swearing at a caregiver).*

10. Regulating or controlling a person's money in a way which they and/or their legal guardian object to *(see also Section H.2 of this policy regarding money management).*

11. Not allowing a person to attend activities, at home or in the community, as a disciplinary consequence *(e.g., not allowing the person to watch TV because they did not do the dishes; not allowing the person to go bowling because they hit a person the day before).* Any use of this procedure requires the prior written approval of the division director.

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Note: If a person is upset immediately prior to an activity, or there is evidence that they are likely to engage in severe problem behaviors at an activity, the activity may be cancelled for the individual. No ETP is required.

G. **Restrictive Procedures Permitted Without an ETP**

The procedures listed below require a behavior support plan (BSP) as specified in this policy *(see Procedures, Section A).*

1. ***Protective*** restrictive procedures have one or more of the following characteristics:

   a. Interrupting or preventing behaviors that are dangerous or harmful to the person or others;
   b. Interrupting or preventing behaviors which cause significant emotional or psychological stress to others; and/or
   c. Interrupting or preventing behaviors which result in significant damage to the property of others.

2. Permitted restrictive procedures for the purpose of protection include, but are not limited to:

   a. Controlling food consumption for those individuals who have behavioral issues related to unrestricted access to food when:
      (i) A long term threat exists to the person's health, as determined in writing by a physician; or
      (ii) A short term threat exists *(e.g., eating raw meat)*; or
      (iii)It is necessary for assisting the person to live within their budget;
   b. Requiring a person to leave an area with physical coercion *(i.e., physically holding and moving the person)* to protect themselves, others, or property;
   c. Using door and/or window alarms to monitor persons who present a risk to others *(e.g., sexually or physically assaultive)*;
   d. Required supervision to prevent dangerous behavior;
   e. Taking away items that could be used as weapons when the person has a history of making threats or inflicting harm with those or similar items *(e.g., butcher knives, matches, lighters, etc.)*;
   f. Removing personal property being used to inflict injury on one's self, others, or property *(removing property belonging to others is not a restrictive procedure)*;
   g. Physical restraint to prevent the free movement of part or all of the person's body with the exception of restraint in a prone or supine position *(i.e., lying on the stomach or back, respectively)* which is prohibited. *(See also DDD Policy 5.17,* ***Physical Intervention Techniques****)*; and

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h. Mechanical restraint to limit the person's free movement or to prevent them from self-injury *(e.g., a helmet, arm splints, etc.)*. Mechanical restraint in a prone position *(lying on the stomach)* is prohibited.

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Note: Splints applied for purposes of physical therapy, or other mechanical devices used to maintain proper body posture, wheelchair safety *(e.g., seat belts or chest straps)*, or devices used to protect a person from accidental injury *(e.g., helmets for persons with seizures, gait belts)*, are not considered restrictive procedures and do not require BSPs.

H. **Non-restrictive Procedures**

1. Teaching, Training and Support Methods

The following procedures are not restrictive and BSPs are not required to use these procedures. Programs or written guidelines to staff are recommended if these procedures are used frequently.

a. Prompting *(verbal, gestural and physical cues, as well as physical assistance)*;
b. Simple correction *(explaining or showing how to do something correctly, coaching and/or guiding the person with or without physical assistance)*. Correction should always be demonstrated in respectful manner;
c. Not attending to specific behaviors that are inappropriate;
d. Offering or suggesting alternatives, discussing options, and discussing consequences of different behaviors;
e. Setting up incentive programs using tokens or points with special motivators *(e.g., extra money, CDs, videos, etc.)*. These incentives must be purchased with money other than the person's;
f. Teaching and encouraging a person to choose and purchase healthy, nutritional food;
g. Canceling an activity for an individual because he or she is agitated at the time of the event;
h. Controlling access to prescription medicines, over the counter medications, and hazardous chemicals that can be harmful *(e.g., laxatives, cleaning fluids, insecticides)*;
i. Physically blocking someone's behavior for protection without holding him or her;
j. Requiring a person to leave an area for protection *(without physical coercion)*; and
k. Use of door and/or window alarms for personal safety and security *(e.g., sexually vulnerable, dementia, traffic safety)*.
l. Use of door and/or window alarms for personal safety and security *(e.g., sexually vulnerable, dementia, traffic safety)*. Consult with the case resource manager (CRM) if you are unsure about other security devices and their programmatic requirements.
m. Use of medical code alert devices for personal health and safety *(e.g., seizures, falls, dementia)*. Medical alert devices such as necklaces and bracelets may be worn on

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the person.

2. Money Management and Support

   a. An important support many people who live in their own homes need is help managing within their financial resources. This may involve limiting, to varying degrees, a person's access to their money to ensure that basic necessities are covered and the person meets their financial obligations. The person should be involved in these activities as much as possible to state personal preferences and increase money management skills.

      Ways to support the person include:
      (i) Developing a budget plan consistent with the person's interests and financial resources;
      (ii) Monitoring weekly expenditures to ensure the person does not overspend;
      (iii) Paying rent and bills on time;
      (iv) Buying food;
      (v) Purchasing clothing and other personal items; and
      (vi) Budgeting money for leisure activities.

   b. The type and amount of assistance needed must be documented in the person's plan (e.g., ISP, IISP, IHP, or IFP). See WAC 388-820-590 to 388-820-680 for more information.

I. Use of Mechanical/Physical Restraints During Medical and Dental Treatment

The use of mechanical or physical restraints during medical and dental treatment is acceptable if under the direction of a physician or dentist and consistent with standard medical/dental practices. Efforts should be made to familiarize the person with the medical/dental procedure so the least restrictive procedure is needed. See also DDD Policy 5.17, *Physical Intervention Techniques*, for more information.

Any use of mechanical or physical restraints is further governed by the following best practice guidelines:

1. The restraint is necessary for safe, effective treatment;

2. The restraint causes no physical trauma and minimal psychological trauma;

3. Consent from the person or his or her legal guardian for treatment and use of restraint has been obtained;

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4. Staff is trained in the safe use of the restraint;

5. The physician or dentist writes an order for the needed restraint;

6. The restraint plan is clearly documented in the person's medical record, including reason for use, type, and expected duration; and

7. The person is monitored while restrained to ensure the restraint is not having adverse effects.

J. **Treatment of Sexual Deviancy**

Appropriate treatment of individuals with a history of sexual assault, inappropriate sexual behaviors, or who have committed illegal acts of a sexual nature, may involve certain restrictions as part of their therapeutic treatment plan. In these cases, the use of restrictive procedures for other than protective purposes may be allowed by exception to policy (ETP) if recommended by a qualified therapist *(i.e., a certified sex offender therapist or therapist with experience in the treatment of sex offenders who have a developmental disability).* The person ***must*** consent to the procedures as part of their therapeutic treatment.

Refer to DDD Policy 15.04, *Community Protection Standards for Intensive Supported Living Services (CP-ISLS)* for additional information and requirements.

K. **Court Ordered Restrictions**

Least Restrictive Alternatives (LRA) are court ordered restrictions that a person agrees to meet as a condition of release. If a person requests assistance in meeting court-imposed restrictive conditions, DDD funded programs or staff may provide that assistance. Programs shall only initiate restrictive procedures that are permitted by this policy. Additionally, all requirements of this policy must be met, including those relating to ETPs.

Restraining Orders: If a person has a court order directing them to have no contact with another person or location, staff may assist the person in adhering to the restraining order. No ETP is required.

L. **Emergency Use of Restrictive Procedures**

1. Emergencies may occur in which a person's behavior presents an immediate risk to the health and safety of the person or others, or a threat to property. In such situations, restrictive procedures permitted in this policy may be used for protective

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purposes. However, the least restrictive procedures that will provide adequate protection must be used, and terminated as soon as the need for protection is over.

No procedures that require an ETP may be used in an emergency other than "restricted access" *(Policy Section F.3)* and as described in 4. below.

2. An incident report must be submitted to the DDD case resource manager or the RHC superintendent or designee for each incident leading to the use of emergency restrictive procedures, in accordance with procedures for reporting incidents.

3. If the same restrictive procedure is used on an emergency basis more than three (3) times in a six (6) month period, efforts must begin immediately to conduct a functional assessment which may result in development of intervention strategies and/or a BSP.

4. For individuals who pose an immediate danger to self or others, it is acceptable to initiate ***restricted access*** and ***required supervision*** immediately *(see Policy Sections F.3 and G.2.d)* without a BSP or ETP if there is reasonable justification. The provider must notify DDD of this action and the Regional Administrator or designee must subsequently approve or disapprove within three (3) working days. Approval must be written with a brief statement of the problem and reason for the restriction. A written BSP, and ETP request if necessary, must be completed within forty-five (45) days.

PROCEDURES:

A. Before implementing restrictive procedures, the program must provide the following documentation on the proposed intervention strategy. Community programs may include this information in the Individual Instruction and Support Plan (IISP) or a separate document. RHCs and ICF/MRs must include this information in a behavior support plan (BSP). Psychologists are responsible for developing the BSPs at RHCs.

The person and/or his/her legal guardian must be involved in discussions regarding the perceived need for restrictive procedures, including:

- The specific restrictive procedures to be used;
- The perceived risks of both the person's problem behavior and the restrictive procedures;
- The reasons which justify the use of the restrictive procedures; and
- The reasons why less restrictive procedures are not sufficient.

1. **Necessary Documentation**

a. A definition of the target behaviors that the restrictive procedures address;

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b. A functional assessment of the problem behaviors, including hypotheses why the person engages in these behaviors;
c. Based on the functional assessment, the positive behavior support strategies that will be used to reduce or eliminate the person's need to engage in the problem behaviors. Refer to DDD Policy 5.14, *Positive Behavior Support*, for more information.
d. A description of the restrictive procedure that will be used, when and how it will be used, and clear criteria for termination;
e. A plan for recording data on the use of the procedure and its effect.

Note: Each use of a restrictive procedure must be recorded except for those procedures where the restrictions are ongoing, such as "restricted access" for Community Protection Program participants. In these cases the person's treatment plan must include documentation of the restrictions and a notation that the restrictions are ongoing.

f. A description of how the program or interdisciplinary team (IDT) will monitor the outcomes of implementing the positive behavior support strategies and evaluate the continued need for restrictive procedures.

2. **Approval Process**

Prior to implementation, the proposed intervention must be approved as follows:

a. **For community programs,**
   (i) All intervention strategies involving restrictive procedures require the written approval of the agency administrator or persons who have designated approval authority; and
   (ii) Intervention strategies that require ETPs or involve physical or mechanical restraints require written approval by the person and/or his/her legal guardian. The person's approval should be sought to the extent he or she understands what is being proposed;
   (iii) Approval must be documented on a form that lists the risks of the problem behavior and the risks of the restrictive procedure, explains why less restrictive procedures are not recommended, and indicates alternatives to the recommendation. Space must be provided for the person and/or guardian to write comments and their opinions regarding the plan.

b. **For RHCs and ICF/MRs,**
   (i) Written approval of the BSP from the IDT;
   (ii) Written consent of the person and/or his/her legal guardian; and
   (iii) Written approval from the Human Rights Committee as described in DDD Policy 5.10, *Human Rights Committee*.

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c. If the person and/or guardian disagree with parts of the proposed intervention strategies/BSP, they may file a grievance according to the procedures of the program or agency. If they are not satisfied with the facility or agency response, they may request a review by the DDD Regional Administrator.

B. **Monitoring Physical/Mechanical Restraint Procedures**

1. Persons being restrained must be observed continuously and without interruption to ensure the risks to the person's health and safety are minimized.

2. Whenever possible, a separate person not involved in restraining the person should observe the procedure.

3. Time in and out of restraint must be recorded.

4. Documentation should include a written description of:

   a. Events immediately preceding the behavior which precipitated the use of restraint;
   b. Type of restraint or intervention;
   c. Duration of the restraint;
   d. Person's reaction to the intervention;
   e. How many staff were involved; and
   f. Any injuries sustained by anyone during the intervention.

C. **Incident Reports**

1. Incident reports are required under the following conditions:

   a. When any injuries requiring first aid and/or medical care are sustained by any person during implementation of a restrictive procedure/intervention; and
   b. Whenever restrictive procedures are implemented under emergency guidelines.

2. Incident reports must be submitted as follows:

   Community programs and SOLAs: as described in DDD Policy 6.12, *Residential Reporting Requirements*; and

   RHCs and ICF/MRs: as described in DDD Policy 12.01, *Incident Management.*

D. **Data Monitoring of Restrictive Procedures**

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1. Program staff responsible for intervention strategies or BSPs must review the plan at least every thirty (30) days.

2. If the data indicates progress is not occurring after a reasonable period, but no longer than six (6) months, the intervention strategies or BSPs must be reviewed and revisions implemented as needed.

3. At least annually, the approving authorities must re-approve restrictive procedures which require ETPs or involve physical or mechanical restraint.

EXCEPTIONS:

Any exceptions to this policy, including restrictive procedures described in Policy Section F, must be reviewed and approved in writing by the DDD Regional Administrator within fifteen (15) calendar days after receipt of the request and required documentation. All ETP requests must be submitted using DSHS Form 02-556, *Request for Exception to Policy for Use of Restrictive Procedures* (Attachment A). A signed consent form must accompany the request (see Attachment B for sample form, *Consent for Use of Restrictive Procedures Requiring an ETP*).

SUPERSESSION:

DDD Policy 5.15
Issued June 17, 1999

DDD Policy 5.15
Issued January 30, 1996

DDD Policy 5.12
Issued December 28, 1993

Approved: ***/s/ Linda Rolfe*** **Date: July 1, 2001**
Director, Division of Developmental Disabilities

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)
REQUEST FOR EXCEPTION TO POLICY (ETP)
FOR USE OF RESTRICTIVE PROCEDURES

LAST NAME	FIRST	MIDDLE	BIRTHDATE	COMMUNITY PROTECTION PARTICIPANT ☐ Yes ☐ No

ADDRESS	CITY	STATE	ZIP CODE

PROCEDURE(S) FOR WHICH EXCEPTION IS REQUESTED

Does this person have a legal guardian? ☐ Yes ☐ No

If yes, answer the following:

LEGAL GUARDIAN'S NAME	TELEPHONE NUMBER (INCLUDE AREA CODE)

AGENCY REQUESTING ETP

AGENCY'S NAME	TELEPHONE NUMBER (INCLUDE AREA CODE)

ADDRESS	CITY	STATE	ZIP CODE

ADMINISTRATOR'S SIGNATURE	DATE	PRINT ADMINISTRATOR'S NAME

DOCUMENTATION

Attach the following documentation per DDD Policy 5.15, Use of Restrictive Procedures:

☐ a. Definition of target behavior(s)
☐ b. Functional assessment or psychosexual evaluation
☐ c. Description of positive behavior support strategies
☐ d. Description of restrictive procedure(s)
☐ e. Data plan
☐ f. Monitoring plan and evaluation plan
☐ g. Written consent of the person
☐ h. Written consent of guardian
☐ i. Other (specify):

REGIONAL ADMINISTRATOR'S DECISION

☐ ETP approved for _____ months (not to exceed 12 months).
☐ Resubmit with modification(s) as specified (or attach additional sheet): _____

_____

☐ ETP not approved.

COMMENTS	SIGNATURE _____ DATE

➢ **DSHS 02-556 (05/1999)**

Rev. 7/1/2006

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➢ CONSENT FOR USE OF RESTRICTIVE PROCEDURES REQUIRING AN ETP

Name of Client: _____ Date of Request: _____
Behavior(s) of Concern: _____
_____
Proposed Restrictive Procedure(s): _____
_____

(In an attached Behavior Support Plan or similar document clearly spell out how and when the procedure(s) will be used, criteria for termination of the procedure(s), and plans for recording the use and effectiveness and for monitoring the continued need for the restrictive procedure(s)).

Risks of Proposed Restrictive Procedure(s): _____
_____
_____
Risks of Not Using Restrictive Procedure(s): _____
_____
_____
Why Less Restrictive Procedures are not Recommended: _____
_____
_____
What are the Alternatives to the Proposed Procedure(s): _____
_____
_____

Approval of Program Administrator: _____ Date: _____

Consent to use Procedures: _____ Date: _____
(Client Signature)

_____ Date: _____
(Guardian Signature)

This consent is valid for _____ months (not to exceed 12 months).

Comments of Client/Guardian:
_____
_____

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TITLE: USE OF PSYCHOACTIVE MEDICATIONS POLICY 5.16

Authority: Chapter 71A RCW Developmental Disabilities
Chapter 388-820 WAC Community Residential Services and Supports

BACKGROUND:

Psychoactive medications have proven to be a very effective treatment for many forms of mental illness. For person with developmental disabilities in whom it is more difficult to make a clear diagnosis of mental illness, but who may nonetheless be suffering from mental illness and/or severe problem behaviors, psychoactive medications can be helpful. This class of medications has potential side effects ranging from mild to severe. Regular monitoring for side effects and evaluation of medication effectiveness is especially important for individuals who have a reduced capacity to communicate symptoms of potential side effects.

Psychoactive medications are not necessarily the first treatment of choice. Positive behavior support approaches may be equally or more effective and treatment decisions should always be made on an individual basis. Refer to Division of Developmental Disabilities (DDD) Policy 5.14, *Positive Behavior Support,* for more information on positive behavior support.

PURPOSE:

This policy establishes guidelines for assisting a person with mental health issues or severe problem behavior to access accurate information about psychoactive medications and treatment, and to make fully informed choices.

SCOPE:

This policy applies to all persons who receive DDD certified and contracted residential services and services through DDD State Operated Living Alternatives (SOLA).

DEFINITIONS:

"Psychoactive medications" means medications prescribed for the purpose of enabling a person to function better, reducing problem behavior, or treating a mental illness. Psychoactive medications are prescribed to alter mood, anxiety level, behavior, cognitive processes, or mental tension. Common groups of psychoactive medications are antipsychotic or neuroleptic medications, antidepressants, antianxiety medications, sedative/hypnotics, psychostimulants, and mood stabilizers.

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POLICY:

Persons with developmental disabilities and mental illness, and/or serious problem behavior, shall have adequate access to information and treatment with psychoactive medications, and reasonable protection from serious side effects or the inappropriate use of these medications.

PROCEDURES:

A. **Assessment and Treatment Plan**

1. If the person appears to be displaying symptoms of mental illness and might benefit from taking a psychoactive medication, the person should be referred for an assessment. If one is available, it is recommended that a psychiatrist, physician's assistant, or nurse practitioner (ARNP) with experience in treating people with developmental disabilities, conduct this assessment.

2. Prior to the assessment, staff should prepare a psychiatric referral summary and send or take this to the treatment professional conducting the assessment. The summary should briefly describe the frequency and severity of the person's symptoms or behaviors and what has been tried previously. See Attachment A for sample form, *Psychiatric Referral Summary*.

   Note: Some individuals may prefer to visit their treatment professional independently and without the assistance of residential agency staff. In such cases, the person's choice should be respected and documented in the person's file.

3. After the assessment, if the treatment professional recommends psychoactive medication, the prescribing professional or agency staff should document the person's treatment plan. See Attachment B for sample form, *Psychoactive Medication Treatment Plan: Introduction of New Medication*. The plan should address the following:
   a. A mental health diagnosis or a description of the behaviors for which the medication is prescribed;
   b. The name(s) and purpose(s) of the medication(s);
   c. The length of time considered sufficient to determine if the medication is effective; and
   d. The behavioral criteria to determine whether the medication is effective *(i.e., what changes in behavior, mood, thought, or functioning are considered evidence that the medication is effective).*

4. Informed consent for administration of the medication by the person, or his or her legal guardian, should be obtained and documented on a form that lists justification for the use of the medication. See Attachment C for sample form, *Consent for Use of Psychoactive Medication.*
   a. An information sheet on the medication(s), including potential side effects, should be attached to the consent form. It is acceptable to use the written information supplied by the dispensing pharmacy.

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b. Agencies should retain a copy of the consent form that is mailed to the person's guardian in the person's file.
c. If the person's guardian refuses to give consent, the agency should encourage the guardian to meet with the treatment professional to discuss the medication issue.

5. There may be situations in which a person's guardian is unavailable to provide consent and the treatment professional wants the person to begin taking the medication immediately. Where the physician believes the medication will alleviate the person's physical or emotional distress, and no significant risks are associated with the medication, the agency should act in the person's best interests and assist them in obtaining and taking their medication. Attempts to gain consent from the guardian must still be actively pursued and documented.

6. Plans to support the person in positive ways that will assist in the treatment or reduction of the person's symptoms/behaviors should be documented in a written plan such as the Behavior Support Plan (BSP), Psychoactive Medication Treatment Plan (PMTP), Individual Service Plan (ISP), or the Individual Instruction and Support Plan (IISP).

B. Monitoring Psychoactive Medications

1. The agency must monitor the person to help determine if the medication is being effective based on criteria identified in the treatment plan. If the medication appears not to have the desired effects, the agency must communicate this to the prescribing professional.

2. The agency must observe the person for any changes in behavior and/or health, which might be side effects of the medication, and inform the prescribing professional of any concerns.

3. The agency should request that the prescribing professional see the person at least every three (3) months unless the prescribing professional has recommended a different schedule.

4. The continued need for the medication should be assessed annually by the prescribing professional. See Attachment D for sample form, *Psychoactive Medication Treatment Plan: Annual Continuation of Medication.*

EXCEPTIONS:

Any exceptions to this policy must be reviewed and approved in writing by the DDD Regional Administrator.

SUPERSESSION:

DDD Policy 5.16
Issued May 26, 1999

DDD Policy 5.16
Issued January 30, 1996

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Approved: */s/ Linda Rolfe* Date: July 1, 2001
Director, Division of Developmental Disabilities

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➢ PSYCHIATRIC REFERRAL SUMMARY

➢

Name: _____ DOB: _____ Age: _____ Gender: M F

Address: _____

Supporting Agency: _____

Contact Person: _____ **Phone: _____**

Legal Guardian: _____ **Phone: _____**

Primary Physician: _____ Phone: _____

Other Physician: _____ Phone: _____

DDD Case Manager: _____ Phone: _____

Form completed by: _____ Date: _____

Relationship to client: _____

_____

Briefly describe why this person is being referred for a psychiatric evaluation: _____

_____

_____

_____

_____

Symptom(s) or behavior(s) of concern (define and state frequency and severity of each symptom or behavior):

_____

_____

_____

_____

Previous mental health involvement (list past counseling, behavioral interventions, diagnoses, medications, psychiatric hospitalizations, crisis team contact, etc.):

_____

_____

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➢ PSYCHIATRIC REFERRAL SUMMARY (continued)

List other agency contacts and phone numbers (employment, vocational, mental health, other therapists, etc.):

_____

_____

_____

What has been tried previously (list intervention and results, if known):

_____

_____

_____

_____

List diagnoses/medical concerns:

_____

_____

_____

_____

_____

Current medications and daily dose:

_____

_____

_____

_____

_____

List any known unusual or adverse reactions to medications:

_____

_____

Describe the following characteristics of the person (if not already listed):

Sleep pattern _____

Mood/affect _____

Eating/appetite_____

Thinking/cognition _____

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Memory _____

➢ PSYCHIATRIC REFERRAL SUMMARY (continued)

Anxiety level_____

Hyperactivity_____

Sensory impairments _____

Allergies_____

_____

Gynecological problems_____

Urinary problems_____

Communication impairment_____

Other Information that may be pertinent:

_____

_____

_____

_____

_____

_____

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➢ PSYCHOACTIVE MEDICATION TREATMENT PLAN
➢ INTRODUCTION OF NEW MEDICATION

Name: _____ DOB: _____ Date: _____

Address: _____

_____

Supporting Agency: _____ Phone: _____

Diagnosis and/or description of behavior for which medication is prescribed:

_____

_____

_____

Medication(s): Dosage:

_____ _____
_____ _____
_____ _____
_____ _____

Length of treatment trial (considered sufficient to determine if medication is effective):

_____

_____

Behavioral criteria to evaluate effectiveness of medication (what changes in behavior, mood, thought or functioning should be expected):

_____

_____

_____

_____

_____ _____

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Prescribing Physician

Agency Staff

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CONSENT FOR USE OF PSYCHOACTIVE MEDICATION

Name: _____ DOB: _____ Date: _____

Medication for which consent is requested: _____

_____

Purpose for which medication is prescribed:

_____

_____

_____

Information on medication: see attached information sheet that describes the medication, dosage ranges, and possible side effects.

Questions regarding the use of this medication should be addressed to the prescribing physician listed below.

Physician:_____ Phone: _____

Consent Statement:

I have received information on this medication, the reasons for its use, and I have had the opportunity to get my questions about it answered. I consent to the use of this medication. I understand that failure to consent to this medication will not result in loss of services from the Division of Developmental Disabilities (DDD). I also understand that I may withdraw my consent at any time, without loss of services from the Division of Developmental Disabilities.

_____ _____
Signature of Client Date

_____ _____
Signature of Guardian Date

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PSYCHOACTIVE MEDICATION TREATMENT PLAN
ANNUAL CONTINUATION OF MEDICATION

Name: _____ DOB: _____ Date: _____

Address: _____

_____

Supporting Agency: _____ Phone: _____

Diagnosis and/or description of behavior for which medication is prescribed:

_____

_____

_____

Medication(s):	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____

Positive results of this medication and justification for continuation:

_____

_____

_____

Plan to continue use of this medication:

_____

_____

_____

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TITLE: PHYSICAL INTERVENTION TECHNIQUES POLICY 5.17

Authority:	Chapter 71A RCW	Developmental Disabilities
	Chapter 388-820 WAC	Community Residential Services and Supports
	Chapter 388-825 WAC	DD Services Rules
	Chapter 388-850 WAC	County Employment and Day Programs

BACKGROUND:

The Division of Developmental Disabilities (DDD) intends to provide services and supports to people with disabilities in the least restrictive and least intrusive manner possible. DDD Policy 5.14, *Positive Behavior Suppor*t, provides guidance and direction on supporting people in positive, helpful ways, and creating supportive environments that avoid the need for physical intervention or restraint.

PURPOSE:

When a person's behavior presents a threat of injury to self or others, threatens significant damage to the property of others, steps must be taken to protect the person, others, or property from harm, including physical intervention if necessary. This policy describes both prohibited and permitted physical interventions, the circumstances under which the permitted interventions may be used, the requirements that must be met before they may be used, and the requirements for documenting and monitoring their use.

Refer to DDD Policy 5.15, *Use of Restrictive Procedure*s, for direction and additional information on the use of all restrictive procedures, including mechanical restraints.

SCOPE:

This policy applies to all persons who receive services in:

1. DDD certified contracted residential programs serving people in their own homes;
2. State-Operated Living Alternatives (SOLA);
3. Intermediate Care Facilities for the Mentally Retarded (ICF/MR);
4. DDD Nursing Facilities; and
5. Services provided by counties that are funded by DDD.

State laws (RCWs) and rules (WACs) governing adult family homes, boarding homes and nursing homes take precedence over this policy. Certain physical interventions, permitted under this policy with a behavior support plan, are prohibited in boarding homes and adult family homes. Administrators of such facilities should refer to Chapters 18.20 and 70.129 RCW.

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DEFINITIONS:

Physical restraint means physically holding or restraining all or part of a person's body in a way that restricts their free movement.

Physical intervention means the use of a manual technique intended to interrupt or stop a behavior from occurring. Physical intervention includes using physical restraint to release or escape from a dangerous or potentially dangerous situation.

POLICY:

A. Physical interventions must be used only as provided for in this policy and as described in DDD Policy 5.15, *Use of Restrictive Procedure*s.

B. Physical interventions must be used only when positive or less restrictive techniques or procedures have been tried and are determined to be insufficient to protect the person, others, or damage to the property of others.

C. Physical interventions may only be used for the purpose of protection, and may not be used for the purpose of changing behavior in situations where no need for protection is present.

D. Only the least restrictive intervention needed to adequately protect the person, others, or property must be used, and must be terminated as soon as the need for protection is over.

E. *Restrictive* physical interventions may only be used as part of an approved behavior support plan (BSP), except in the case of an emergency or unknown, unpredicted response from a person where his or her safety, or that of others, is jeopardized.

F. Prohibited Physical Interventions

1. **Physical interventions that involve any of the following elements are prohibited:**

    a. Pain and pressure points *(whether for brief or extended periods)*;
    b. Obstruction of airway and/or excessive pressure on chest, lungs, sternum, and diaphragm;
    c. Hyperextension *(pushing or pulling limbs, joints, fingers, thumbs or neck beyond normal limits in any direction)* or putting the person in significant risk of hyperextension;
    d. Joint or skin torsion *(twisting/turning in opposite directions)*;
    e. Direct physical contact covering the face;
    f. Straddling or sitting on the torso;
    g. Excessive force *(beyond resisting with like force)*; and
    h. Any maneuver that involves punching, hitting, poking or shoving the person.

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2. **The following specific techniques are also prohibited:**

   a. Arm or other joint locks *(e.g., holding one or both arms behind back and applying pressure, pulling or lifting)*;
   b. Sleeper hold or any maneuver that puts weight or pressure on any artery, or otherwise obstructs or restricts circulation;
   c. Wrestling holds, body throws or other martial arts techniques;
   d. Prone restraint *(person lying on stomach)*;
   e. Supine restraint *(person lying on back)*;
   f. Head hold where the head is used as a lever to control movement of other body parts;
   g. Any maneuver that forces the person to the floor on his/her knees, or hands and knees;
   h. Any technique that keeps the person off balance *(such as shoving, tripping, pushing on the backs of the knees, pulling on the person's legs or arms, swinging or spinning the person around, etc.)*; and
   i. Any technique that restrains a person vertically face first against a wall or post.

G. Physical Restraints Permitted Only With A Behavior Support Plan (BSP)

The physical interventions listed below are considered restrictive restraint interventions and must be incorporated in a BSP or an intervention strategy that is part of the person's Individual Instruction and Support Plan (IISP).

1. Hand, arm, and leg holds;
2. Standing holds;
3. Physically holding and moving a person who may be resisting;
4. Head holds *(Note: physical control of the head is permitted only to interrupt biting or self-injury such as head banging)*;
5. Person seated on furniture and physically restrained by two persons sitting on either side; and
6. Person sitting on floor, being physically restrained by one or more persons.

H. Physical Interventions Permitted Without A Behavior Support Plan (BSP)

The following nonrestrictive physical interventions are permitted. Interventions are listed in order from least intrusive to most intrusive. *Note:* these interventions may be used in boarding homes and adult family homes.

1. **Avoiding -** eluding/escaping physical contact through the use of slides, stance, and arm/hand maneuvers without holding on to the body of the person;

2. **Deflecting** - using physical contact, such as step and guide maneuvers;

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3. **Blocking** - obstructing or hindering using physical contact;

4. **Releasing** - escaping a physical hold. This may involve holding on briefly to the person to release oneself and/or another persons; and

5. **Supporting Ambulation** - physically holding a person to steady or support them while walking to keep them from falling or slipping. This may involve the use of gait belts, specially designed belts, vests or clothing. *Note:* the person doing the supporting follows the lead of the person being supported. The person must be released when he or she no longer needs physical support.

I. Use of Physical Interventions During Medical and Dental Treatment

The use of permitted physical interventions during medical and dental treatment is allowable if under the direction of a physician or dentist, consistent with standard medical/dental practices, and necessary to complete a medical or dental procedure. Efforts must be made to familiarize the person with the medical/dental procedure so the least restrictive physical intervention is needed.

J. Emergency Use of Physical Interventions

1. "Emergency" means an extreme hazard or an unanticipated, unpredicted action by a person which puts the person or others at risk and jeopardizes the health and safety of the person or others *(e.g., when a person is standing or sitting in the street, when a person is at immediate risk of danger from a fire).*

2. In an emergency, physical interventions that are normally permitted only with an approved BSP may be used for protective purposes.

3. In certain extreme emergency situations where a person or others cannot be kept safe from real harm except by interventions that are otherwise prohibited by this policy, it is permissible to use such interventions if reasonably necessary to protect the person or others. The least restrictive intervention must be used, and must be terminated as soon as the need for protection is over.

4. An incident report must be submitted to the DDD case resource manager or the RHC superintendent or designee for each incident involving emergency use of restrictive physical interventions, in accordance with procedures for reporting incidents.

5. If the same restrictive physical intervention is used on an emergency basis more than three (3) times within a six (6) month period, a functional assessment that may result in development of intervention strategies and/or a BSP must be conducted.

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PROCEDURES:

A. *Documentation and Approval of Restrictive Physical Interventions*

1. Prior to implementing restrictive physical interventions, the facility or agency must provide documentation on the proposed intervention and approval for its use, according to the requirements set forth in DDD Policy 5.15, *Use of Restrictive Procedure*s.

2. The person and his or her guardian must be involved in discussions regarding the perceived need for physical intervention. The level of notification parents and/or guardians desire when physical interventions are used should also be determined at this time.

B. *Implementation of Physical Interventions*

1. All staff using physical interventions must have prior training in the use of such techniques according to the facility or agency's policy and procedures. With all training on the use of physical interventions, staff must also receive training in crisis prevention techniques and positive behavior support.

2. A trained person must be present whenever possible to supervise and observe during use of restrictive physical interventions. Designated staff must receive training in observation and supervision of physical restraints *(e.g., signs of duress, fatigue, etc.)*.

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3. Each facility or agency must make provisions for a post-analysis *(i.e., what could have been done differently)* whenever restrictive physical interventions are implemented in emergencies, or when the frequency of use of the intervention is increasing. The person, staff and supervisor involved, and other team members must participate, as appropriate.

C. Monitoring Restrictive Physical Interventions Procedural requirements for monitoring restrictive physical interventions are described in DDD Policy 5.15, *Use of Restrictive Procedure*s, including:

1. Documenting the use of interventions;
2. Incident reporting; and
3. Data monitoring and review.

COMPONENTS OF A PHYSICAL INTERVENTION TECHNIQUES SYSTEM

This section describes the necessary components of a physical intervention techniques system used by a facility or agency.

A. Physical intervention systems used by facilities and agencies must include, at a minimum, the following training components:

1. Discussion of the need for positive behavior support;

2. Communication techniques that help a person calm down and resolve problems in a constructive manner;

3. Techniques to prevent or avoid escalation of behavior prior to physical contact;

4. Techniques for staff to use in response to their own feelings or expressions of fear, anger, aggression, etc.;

5. Techniques for staff to use in response to the person's feelings of anger or aggression, etc.;

6. Cautions that physical intervention techniques may not be modified except as necessary in consideration of individual disabilities, medical, health, and safety issues. An appropriate medical/health professional and the facility or agency certified trainer must approve all modifications;

7. Evaluation of the safety of the physical environment at the time of the intervention;

8. Issues of respect and dignity of the person;

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9. Use of the least restrictive physical interventions depending upon the situation;

10. Clear presentation and identification of approved and prohibited physical intervention techniques;

11. Discussion of the need to release persons from physical restraint as soon as possible;

12. Instruction on how to support physical interventions as an observer, recognizing signs of distress by the person and fatigue by the staff; and

13. Discussion of the importance of complete and accurate documentation.

B. Staff receiving physical intervention techniques training must complete the course of instruction and demonstrate competency before being authorized to use the techniques with clients.

C. Review of de-escalation techniques and physical intervention techniques by staff must occur annually.

EXCEPTIONS TO POLICY:

Any exceptions to this policy must be reviewed and approved in writing by the DDD Regional Administrator within fifteen (15) calendar days after receipt of the request and required documentation. All ETP requests must be submitted using DSHS Form 02-556, *Request for Exception to Policy for Use of Restrictive Procedure*s.

SUPERSESSION:

DDD Policy 5.17
Issued July 24, 1997

Approved: */s/ Linda Rolfe* Date: July 1, 2001
Director, Division of Developmental Disabilities

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PROVIDER QUALIFICATIONS
Behavior Rehabilitation Services (BRS)

Service Description:
The Behavior Rehabilitation Program uses intensive resources to create an environment in which supervised group and/or family living are integrated into a comprehensive program in which positive behavioral support methods and environmental structure are provided, tailored to the child's and family's needs and offered in the least restrictive setting possible.

Contracted providers of BRS will deliver services within the State of Washington. An exception would be made for facilities located outside the state which are sited within fifty miles of the border and which can facilitate reunification between the child and their family resource within Washington State.

Quality of the Service Environment:
The following qualifications, organized into four sections – supervision, permanency planning, program structure, and service planning – are designed to ensure that contracting organizations are capable of providing behavior rehabilitation services in a way that is congruent with the policies, procedures, philosophies, outcomes and mandates of the DSHS Children's Administration. Successful provision of this program will be regulated by:

- *Washington State minimum licensing requirements for group homes, staffed residential homes, and/or foster homes,*
- *The Americans with Disabilities Act,*
- *The Indian Child Welfare Act, and*
- *Other federal mandates such as the Adoption and Safe Families Act, and PL 96-272.*

Additional guidance for program operation is located in RCW, WAC, Children's Administration Policies, the contract, and in the Department's placement considerations.

The Children's Administration reserves the right to conduct on-site visits as part of the initial and on-going qualifications process to ensure that the evidences submitted are expressed in the daily practice of the agency.

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PERMANENCY PLANNING

The contractor shall focus on children's needs for a safe and stable home and for a family resource that will be involved with the service plan and support the child during the service period, as well as be a long-term resource for the child into adult life.

QUALIFICATION	ADDITIONAL INSTRUCTIONS
1. Focus on Permanency Goals: • maintain family and kinship connections where possible • assist in development of long term resources for the child • work within the established court timelines, court orders, and Individualized Service and Safety Plan (ISSP) requirements	This qualification addresses federal requirements set forth in PL 96-272 and the Adoption and Safe Families Act that require children achieve their permanent plans quickly. It reaffirms commitment to permanency for the child and demonstrates knowledge of and planning for the implementation of the permanent plan. It also recognizes that the definition of family/family resource as defined in the contract includes all family, kinship, cultural, and fictive kinship relationships significant in the child's life.

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SUPERVISION

This requirement addresses staff-initiated activities built into the program structure that attempt to guarantee that a child's safety will not be jeopardized due to inadequate supervision, which could lead to accidents or to dangerous encounters with other residents. It does not include safety issues related to the physical plant and which are addressed through licensing.

QUALIFICATION	ADDITIONAL INSTRUCTIONS
2. Adequate supervision and structure to assure child safety	This qualification looks at strategies that are built into the program structure that direct staff behavior and attention to each individual child's safety and well-being. Staff to child ratios for contracted Behavior Rehabilitation Services are expected to be above the current minimum licensing requirements. The required staff to child ratio will be contained in the contract and will vary based on the physical environment in which services are delivered and the service level combinations the agency is qualified and contracted to serve.
3. Respect for individual child's right to safety and well-being	This qualification reflects the value and priority demonstrated by staff and management regarding children's needs for safety and well-being. The modeling of respect, by staff for residents, should lead to expectations of respect between residents, which should enhance other safety efforts and contribute to children's well-being. It also addresses individualized planning designed to meet each child's unique needs.
4. Process in place for children and/or families to air concerns regarding safety and well-being	This qualification is meant to provide a forum in which children and/or families can make known their concerns regarding safety, respect, and well-being. While a process for "house meetings" to help residents resolve issues among themselves would be a part of this process, it would also include additional mechanisms through which children or their families can make known their needs for safety and respectful treatment.

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PROGRAM STRUCTURE

This requirement addresses the organization of the contracting agency, its programs, resources, models of service delivery, mission, and values. It examines the program infrastructure of the agency to ensure that the agency has the capability to serve the children and families referred for services.

QUALIFICATION	ADDITIONAL INSTRUCTIONS
5. Rehabilitative services available from qualified program staff who are supported in their ability to do the job.	This qualification looks at the ability of staff to do the job. It is meant to ensure that staff are being hired with the appropriate credentials for the position that they hold, that their workload is reasonable and that they are provided skill-building opportunities through training, mentoring, supervision, on-the-job training, etc. This also addresses the responsibility of the contracting organization to ensure that the staff of any subcontractors are also appropriately qualified.
6. Program and service plan developed based on child and family strengths, to encourage and assure child and family successes.	This qualification demonstrates the value held by the contracting organization to work from a strengths-based, not a deficit-based treatment model.
7. Resources available to respond to child's need for educational support	This qualification addresses the need of children to have someone available in their home environment to facilitate school success -- by providing an environment conducive to study, a time set aside with help available for homework or tutoring, and other enriching activities that supplement or build on the school curriculum. This qualification also assumes that residential staff and/or family members will be involved with the school, attending conferences and staffings, and having regular conversations with school personnel. It may include volunteer tutors or community members who can provide hands-on experience or demonstrate the importance of the subject matter.
8. Resources *(e.g. staff, clinical oversight, structure)* available to stabilize the presenting issues, and provide the capacity to develop supports and appropriate transition plans.	This qualification looks at the ability of the contracting organization to provide immediate intervention to stabilize children upon their placement in the program; to provide the resources needed by the child and family to be successful; and to identify, develop, and implement an array of services so children can move to the most normative, least restrictive service and

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	placement option.

PROGRAM STRUCTURE *(Continued)*	
QUALIFICATION	**ADDITIONAL INSTRUCTIONS**
9. Process for ensuring the ongoing quality of programming and ensuring the organization's ability to change programming to meet changing needs of the organization and of the consumer.	This qualification demonstrates the commitment of the contracting organization to continuous quality improvement and to assurance of high quality, appropriate services which are aligned with best practice.
10. Capacity to identify and respond to immediate and emergent health needs or injuries	This qualification looks at the ability of the contracting organization to meet the physical health and safety needs of children in the program.
11. Process in place for managing crises and emergencies	This qualification recognizes that prevention is better than intervention, but if a situation occurs that requires immediate, clear, direct intervention from staff, there must be a protocol in place which guides response. It also requires that staff be trained to, and have experience or practice with, the protocol. This would include crises which are triggered by the acting out of individual children which impact the population as a whole, and community crises such as earthquakes, power outages etc.
12. Mechanism in place for child &/or family to formally grieve conflicts/disagreements	This qualification demonstrates the intent of the contracting organization to hear consumer issues and to provide for mediation of problems. It includes a formal documented process for grieving that is communicated clearly to the child and family and a process for developing action steps to resolve the issues.

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SERVICE PLANNING

This requirement addresses the ability of the contracting agency to identify and meet the unique service needs of the child and family and to demonstrate appropriate progress toward meeting the child's and family's identified goals and toward the permanency planning goal. It also assumes that the contracting agency will provide leadership to the treatment team and with its service partners in assuring that services are individualized for the family and provided in the way that best meets the child's and family's needs and desires.

QUALIFICATION	ADDITIONAL INSTRUCTIONS
13. Culturally responsive services	This qualification demonstrates the ability of the contracting organization to provide appropriate, accessible, and culturally relevant services to children and their families. It examines how service delivery is culturally competent and responsive to each program participant's cultural beliefs and values, ethnic norms, language needs, and individual differences. This also includes how the program recognizes and celebrates the cultural, ethnic, and racial identity of its participants; provides linkages to community events and cultural activities; provides ethnic food and supports daily rituals.
14. Family, tribal, and other collateral system inclusion in planning and service delivery	This qualification demonstrates the priority of the contracting organization around collaborative planning, including the child's family and all systems serving and/or potentially serving the child and family.
15. Development of linkages with community resources	This qualification addresses the need for the contracting organization to have an established network of community partners to help meet the treatment, social, recreational, educational, and emotional, cultural, ethnic, and/or religious needs of children participating in program.
16. Proactive behavior management planning, individualized to the needs of the child and consistent with WAC and CA policies	This qualification asks that contracting organizations include in the treatment plan tailored strategies, based on assessment results, to prevent, minimize, or strategically intervene in problem behaviors of children participating in the program. It also assumes that staff are aware of and trained to the behavior management strategies for each child they serve. This qualification also asks that contracting organizations document their understanding of and

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	adherence to DSHS-established requirements and limitations regarding behavior management strategies.

SERVICE PLANNING *(Continued)*	
QUALIFICATION	**ADDITIONAL INSTRUCTIONS**
17. Strengths and needs assessments of • child • family system • community supports, as appropriate to service level	This qualification looks for use of assessment tools designed to identify strengths of each entity – the child, the family, and the community. This item targets the tools used to assess the strengths, while previous items have targeted the philosophy and mindset of the contracting organization and its staff.
18. Development of service plans which relate directly to the child's/family's assessed needs and strengths and to the permanency planning and treatment goals	This qualification assures that all service and treatment activities initiated with the child and family are based on assessment results, treatment goals, child and family choice, social worker input, court orders, and permanency planning goals. It would include plans to provide independent living skills training for appropriate children, minimally including all those age 16 or older whose enrollment in the program is expected to exceed one month.
19. Ability to develop and maintain appropriate timelines for service delivery	This qualification looks at the ability of the organization to set goals and structure services to accomplish the goals in a timely way. It also looks at the ability of the organization to recognize and encourage incremental progress and to adjust when necessary so that goals are reached as quickly as possible. It includes knowledge of DSHS permanency planning timelines and the expectation that Behavior Rehabilitation services are time limited in nature.
20. Continuous review of child's progress, with resulting changes in level of supervision, privileges, treatment focus, treatment location, and living situation	This qualification examines the ability of the contracting organization to regularly assess both formally and informally, the child's progress toward goals and the child's ability to successfully function in the placement environment. It includes ability to respond flexibly to a child's supervision needs and to provide developmentally and behaviorally appropriate treatment and skill-building opportunities.
21. Plan in place for each child regarding appropriate education by an accredited school program	This qualification assures that contracting organizations have addressed children's needs for education while being served by the contracted program
22. Plan in place for each child	This qualification addresses the DSHS requirement

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SERVICE PLANNING *(Continued)*	
QUALIFICATION	**ADDITIONAL INSTRUCTIONS**
regarding adequate and appropriate health care	that children must have a well child exam within 30 days of placement and that vision, dental, and hearing evaluations be completed. It also identifies who within the contracting organization has responsibility for making and keeping appointments, following up on treatment recommendations, and reporting health information to the Passport nurse in DSHS. Management of medications is an important component of this qualification.
23. Ability to develop and support transition plans for children	This qualification addresses the need for children to have smooth, seamless and supported transitions into and out of the contracting organization's programs to other placements, facilities, or programs, or to independent living.

SERVICE SPECIFIC REQUIREMENTS In addition to the qualifications that all providers must have, there are some additional requirements that providers in specific service categories must have. Listed below are the requirements that contracting agencies must meet for the specific populations they serve.	
SHORT TERM SERVICES	
ASSESSMENT	
QUALIFICATION	**ADDITIONAL INSTRUCTIONS**
24. Capacity on site or through a qualified and approved subcontractor to conduct comprehensive assessments of children and family systems	This qualification addresses the focus of this service on providing in-depth information about a child and family to help in identifying appropriate next steps and in developing a longer term plan for the child and family
25. Generate assessment reports which: • incorporate multiple sources of information • analyze strengths and needs of the child • analyze strengths and needs of the family system • identify needed community supports	This qualification addresses the need of DSHS for comprehensive information to help plan for the child long term.

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SERVICE SPECIFIC REQUIREMENTS In addition to the qualifications that all providers must have, there are some additional requirements that providers in specific service categories must have. Listed below are the requirements that contracting agencies must meet for the specific populations they serve.	
SHORT TERM SERVICES	
ASSESSMENT	
QUALIFICATION	**ADDITIONAL INSTRUCTIONS**
• address mental health status of child • document monitoring and review of medications • address permanency needs of the child	
26. Ability to serve referred child and family within four hours of referral, seven days a week, 24 hours a day, based on openings	This qualification responds to the need for an immediate resource and response in a crisis situation.
INTERIM CARE	
27. Ability to serve referred child and family within four hours of referral, seven days a week, 24 hours a day, based on openings	This qualification responds to the need for an immediate resource and response in a crisis situation
28. Ability to work with community resources to transition the child to less intensive services	This qualification recognizes that this is a short term service and that planning must begin very early to move the child to other services meeting the child's needs once the situation is stable. It also recognizes the need for relationships between the contracting organization and its community partners in planning for the child.
29. Ability to work with more intensive resources, as needed per the treatment plan	This qualification recognizes that this is a short term service and that planning must begin very early to move the child to other services meeting the child's need for care. It also recognizes the need for relationships between the contracting organization and the providers of more intensive services.
On-going Services for Children With:	
BEHAVIORAL AND EMOTIONAL DISTURBANCE	
30. Plan to obtain needed psychiatric and psychological care	This qualification recognizes that youth referred for this service may be in need of mental health supports beyond behavior stabilization. It looks at the

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SERVICE SPECIFIC REQUIREMENTS In addition to the qualifications that all providers must have, there are some additional requirements that providers in specific service categories must have. Listed below are the requirements that contracting agencies must meet for the specific populations they serve.	
SHORT TERM SERVICES	
ASSESSMENT	
QUALIFICATION	**ADDITIONAL INSTRUCTIONS**
	treatment resources which would be available to the child while enrolled in the program and at collaborative relationships with community providers, in providing for the child's mental health needs.
31. Capacity for crisis management and behavior de-escalation	This qualification recognizes that a proactive approach to managing the behaviors of difficult children is the appropriate strategy and that behavioral acting out is common with this population. This qualification focuses on crisis plans specific to the needs of each individual child.
32. **At the 1A and 1B service level**: Ensure professional oversight to service plan development and service delivery	This qualification requires that the contracting organization have professional staff with a minimum of Masters-level credentials, either on staff or subcontracted, to provide oversight in the development of the service plan.
33. **At the 1A and 1B service level**: Ensure that resources for adequate and appropriate supervision are available specific to the intensive needs of children in these categories.	This qualification recognizes that children at these service levels have high needs for individualized supervision and monitoring. It also recognizes that children need as normal a range of opportunities and experiences as possible. This qualification looks at the full array of resources for monitoring children. It includes the ability to adjust staff/child ratios to meet the child's needs, the use of alarms and motion detectors, and the availability of adequate supervision to include the child in community and group activities.

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SERVICE SPECIFIC REQUIREMENTS *(Continued)*	
SHORT TERM SERVICES	
SEXUAL AGGRESSION	
QUALIFICATION	**ADDITIONAL INSTRUCTIONS**
34. Washington State certified SO treatment specialist available	This qualification recognizes that specialized professional training is needed to meet the treatment needs of this population and that the treatment plans for these youth will include unique elements not needed by other populations
35. Specialized treatment for sexual aggression	This qualification recognizes that specialized professional training is needed to meet the treatment needs of this population and that the treatment plans for these youth will include unique elements not needed by other populations
36. Individualized treatment for issues other than sexual aggression	This qualification recognizes that youth with SAY issues are likely to have other issues as well and that treatment resources must be prepared to serve the whole child
DEVELOPMENTAL DISABILITIES	
37. Adherence to a multidisciplinary approach to serving children involving all professional disciplines working with the child; but at minimum involving the school district, the Division of Developmental Disabilities social worker, the health care provider, and the Guardian ad litem.	This qualification recognizes that multiple systems are likely to be involved with and have responsibility for the health, welfare, and developmental progress of children in this service category. Further, that to maximize children's functioning, all involved systems must be working together to support services provided across all systems.
38. Service plan development and oversight by staff with training and education regarding the specific disabilities of the children they serve	This qualification ensures that staff who develop and implement treatment plans for clients with developmental disabilities have the appropriate licensure *(where a license is required to provide services)* or credentials, and/or the appropriate experience, education, and training. It should also ensure that staff have a demonstrated ability to work with children with specific disabilities. In addition, It ensures that the plans they develop include strategies for normalization and

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SERVICE SPECIFIC REQUIREMENTS *(Continued)*	
SHORT TERM SERVICES	
	maximizing the child's development.
FRAGILE MEDICAL CONDITIONS	
QUALIFICATION	**ADDITIONAL INSTRUCTIONS**
39. Capacity to provide a range of intensive medical care	This qualification recognizes that specialized medical training and equipment is needed to meet the needs of this population.
40. Medical and nursing oversight	This qualification meets the need for professional oversight of medical treatment and personal care required by this population.

APPENDIX F
"Healthy Kids"

(To be provided at a later date)